83-1149

No.

In the Supreme Court of the United States

OCTOBER TERM, 1983

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

EULA B. STARNES, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTION PRESENTED

Whether the district court had jurisdiction under 28 U.S.C. (& Supp. V) 1331 or 1361 to entertain respondents' challenge to the amount of benefits payable for a particular medical procedure under Part B of the Medicare Program, notwithstanding the jurisdictional bar in 42 U.S.C. 405(h) and 1395ff.

PARTIES TO THE PROCEEDING

In addition to the Secretary of Health and Human Services, the petitioners are Blue Cross and Blue Shield of South Carolina, Inc., and Prudential Insurance Company of America, which have contracted with the Secretary to administer the Part B Medicare Program on her behalf. They were named in the complaint as representatives of a defendant class consisting of all Medicare Part B carriers (C.A. App. 11), but the district court did not certify a defendant class.

The named respondents are: (1) Eula B. Starnes, Johnnie Kaye Lloyd, Nettie E. Clarkson, Jayne E. Dunlap, and Mae T. Sanders, who are individuals enrolled under Part B of the Medicare Program; (2) Julian Adams, O. Rhett Talbert, Fred H. Allen, Jr., and William H. Stuart, who are physicians who utilize computerized tomography (CT) scanners in connection with medical services furnished to Medicare beneficiaries; and (3) Trident Neuro-Imaging Laboratory (a South Carolina general partnership in which Talbert is a partner), CT Scanlab (a North Carolina limited partnership in which Allen is a partner), and Atlanta Neurological Clinic, P.C. (a Georgia corporation in which Stuart is a shareholder), each of which owns and operates CT scanner equipment used in furnishing services to Medicare beneficiaries. Respondents Starnes, Lloyd, Clarkson, Dunlap, and Sanders represent a class of all Medicare beneficiaries who are enrolled in Part B and who have sought or would like to receive Medicare benefits for CT scan services. The other named respondents represent a class of all physicians and physician-directed clinics that own, operate, and use CT scanners in providing services to Medicare Part B beneficiaries. App., *infra*, 30a-31a.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services and two insurance carriers that administer the Part B Medicare Program on behalf of the Secretary, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-18a) is reported at 715 F.2d 134. The March 4, 1980 order of the district court entering a preliminary injunction (App., *infra*, 20a-28a), the October 19, 1981 order of the district court regarding class certification (App., *infra*, 29a-31a), and the April 15, 1982 order of the district court denying the motion to dismiss and certifying the jurisdictional issue for interlocutory appeal to the court of appeals pursuant to

28 U.S.C. 1292(b) (App., *infra*, 32a-40a) are not reported.

JURISDICTION

The judgment of the court of appeals was entered on August 16, 1983 (App., *infra*, 19a). On November 10, 1983, the Chief Justice extended the time within which to file a petition for a writ of certiorari to and including January 13, 1984. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

28 U.S.C. (Supp. V) 1331 and 28 U.S.C. 1361 and relevant provisions of the Social Security Act are reproduced at App., *infra*, 41a-42a.

STATEMENT

This case concerns the jurisdiction of a federal district court to entertain a challenge to administrative guidelines affecting the amount of benefits to be paid under Part B of the Medicare Program for a particular medical service.

1. The Medicare Program is divided into two parts. Part A of the Act (42 U.S.C. (& Supp. V) 1395c *et seq.*) provides insurance for the reasonable cost of hospital and related post-hospital services. 42 U.S.C. (& Supp. V) 1395c and 1395d. Part B of the Act (42 U.S.C. (& Supp. V) 1395j *et seq.*), at issue here, establishes a voluntary program of supplementary medical insurance covering, in general, 80% of the "reasonable charge" for physicians' services, medical supplies, and radiology, pathology, and diagnostic testing services. 42 U.S.C. (& Supp. V) 1395k, 1395*l* and 1395x(s).

Under 42 U.S.C. (& Supp. V) 1395u, the Secretary of Health and Human Services is authorized to enter

into contracts with private insurance carriers to administer the payment of Part B claims on behalf of the Secretary. *Schweiker* v. *McClure*, 456 U.S. 188, 190 (1982). Under these contracts, the carriers determine whether particular services are covered by Part B and the amount of the "reasonable charge" for such services. These determinations are made in accordance with regulations and policy guidelines issued by the Secretary, through the Health Care Financing Administration (HCFA) in the Department of Health and Human Services. 42 C.F.R. 405.502(d).[1] The Secretary is expressly authorized to issue such rules and regulations and to establish procedures to carry out the provisions of the Medicare Program. See 42 U.S.C. 405(a), as made applicable to the Medicare Program by 42 U.S.C. 1395ii; *Heckler* v. *Campbell*, No. 81-1983 (May 16, 1983), slip op. 7-8.

If the carrier finds that the services are not covered by Part B or determines that the payment due is less than the amount claimed, the beneficiary or his assignee is entitled to have the claim reconsidered by the carrier. 42 C.F.R. 405.807-405.812. If the claim again is denied and the amount remaining in contro-

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[1] 42 C.F.R. 405.502(d) provides:

Responsibility of Administration and carriers. Determinations by carriers of reasonable charge are not reviewed on a case-by-case basis by the Health Care Financing Administration, although the general procedures and performance of functions by carriers are evaluated. In making determinations, carriers apply the provisions of the law under broad principles issued by the Health Care Financing Administration. These principles are intended to assure overall consistency among carriers in their determinations of reasonable charge. The principles in §§ 405.503-405.507 establish the criteria for making such determinations in accordance with the statutory provisions.

versy is $100 or more, the claimant is entitled to an oral evidentiary hearing conducted by the carrier. 42 U.S.C. 1395u(b)(3)(C); see *Schweiker* v. *McClure*, 456 U.S. at 191.

Under 42 U.S.C. 1395ff(b)(1)(C) and (2), an individual is entitled to judicial review of the "amount of benefits under part A" of the Medicare Program if the amount in controversy after completion of administrative review of a particular claim is $1,000 or more.[2] There is, however, no comparable provision in 42 U.S.C. 1395ff for judicial review of the "amount of benefits" determined to be payable on a claim under Part B of the Medicare Program. In *United States* v. *Erika, Inc.*, 456 U.S. 201, 206-211 (1982), this Court held that the text and legislative history of 42 U.S.C. 1395ff showed that Congress "deliberately intended to foreclose further review of such claims" (456 U.S. at 208).

2.a. This case involves a challenge to the amount determined to be the "reasonable charge" under Part B of the Medicare Program for particular medical services: computerized tomography (CT) scans. Head scans using approved models of equipment have been covered by the Medicare Program since September 1976, and body scans have been covered since August 1978 (C.A. App. 31). Because CT scans were new and relatively expensive diagnostic techniques when they were first approved for coverage under Medicare, they had been the subject of several studies regarding their effectiveness, utilization, and cost. In

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[2] Under 42 U.S.C. 1395ff(b)(1)(A) and (B), an individual who is dissatisfied with the Secretary's determination of his eligibility to participate in the Part A or Part B Program also is entitled to judicial review. These provisions are not at issue here.

June 1977, the Regional Medicare Director for Region IV of the Medicare Bureau (the predecessor to HCFA) sent letters to carriers in that Region informing them of these studies and expressing concern about the increasing variance in charges allowed by carriers in processing claims for CT head scans (*id.* at 27-28). The letters also proposed to include in the next "allowable charge update (fiscal year 1978)" a $150 "reimbursement ceiling" on CT head scans (*id.* at 28).

In December 1977, the Medicare Bureau issued a memorandum to all Regional Medicare Directors stressing the importance of assuring that carriers, when processing claims for CT scans, take into account not only the customary and prevailing charge for the service but also provisions of the Medicare regulations requiring that the charge for a specific service be "inherently reasonable" (C.A. App. 29-30). See 42 C.F.R. 405.502(a)(4) (1977). Subsequently, in September 1978, HCFA issued a formal Intermediary Letter 78-38 to all Medicare carriers to provide "direction and guidance to carriers as to how they should proceed when applying the reasonable charge methodology to develop screens for new and costly medical services and diagnostic procedures, such as CT scans" (C.A. App. 31). The Letter cited several studies concluding that the average charges for CT scan services were excessive (*id.* at 33) and noted that the National Guidelines for Health Planning issued in March 1978 "established 2,500 scans per year as the minimum operating standard" for each equipment unit (*id.* at 32). At that level of service, the Letter explained, a study by the Blue Cross Association had concluded that the technical component of each scan would generally cost less than $115 (*ibid.*)

and a study by the National Academy of Sciences had concluded that a $35 limit on the physician's interpretation fee would be appropriate (*id.* at 33).

Against this background, the Intermediary Letter "strongly recommend[ed]" that carriers implement charge screens reflecting overall limits of $157.50 for CT head scans and $178.50 for CT body scans, covering both the technical component and the physicians' interpretation fee (C.A. App. 33). The Letter contemplated that there would be future adjustments to the recommended limitations "to take into account evolving program experience, changing technology, or other relevant factors" (*id.* at 35). It also stated that an allowance above the recommended limits should be permitted "in individual claims involving unusual medical complications or circumstances" (*ibid.*) or in situations in which a CT scan unit had been approved by the state or local health planning agency but could not achieve normal utilization because of its location in a sparsely populated area (*id.* at 36).

b. The instant suit was filed in the United States District Court for the District of South Carolina on November 27, 1979, challenging the amount of Part B benefits payable for CT scan services as a result of the 1977 agency memoranda and the 1978 Intermediary Letter. The named plaintiffs, the named respondents herein, are three medical clinics that own and operate CT head scanning equipment, four physicians who are affiliated with such clinics, and five Medicare Part B beneficiaries who have received services at one of the clinics (App., *infra*, 3a). The district court certified two nationwide classes represented by the plaintiffs: (1) a class of all past, present and future beneficiaries enrolled in the Part B Program who "have sought or desire to secure Medicare reimbursement for CT head scan services * * *";

and (2) a class of "all physicians and physician-directed clinics which now (or in the future) own, operate and use CT scanners in rendering head scan services to Medicare patients enrolled under Part B * * *." App., *infra*, 30a-31a.

The complaint alleged that the 1977 agency memoranda and the 1978 Intermediary Letter were promulgated in violation of the notice and comment rulemaking requirements of the Administrative Procedure Act (APA), 5 U.S.C. 553, and violate the provisions of the Medicare statute and regulations governing the determination of the reasonable charge for services under Part B. The complaint further alleged that the memoranda and Intermediary Letter violate the plaintiffs' rights to due process and equal protection under the Fifth Amendment because they were issued without notice and comment and were arbitrary and capricious and because the determination of the limitations differed from that applicable to other Part B services, differed from the method of reimbursement for CT scans under Part A of the Medicare Program, and (insofar as Region IV was concerned) differed from reasonable charge calculations for other regions in the country. C.A. App. 15-17.

On October 6, 1980, the district court entered a preliminary injunction barring enforcement of the limitations on payments for CT head scans until such time as the Secretary promulgated regulations authorizing the Department to set specific reimbursement levels for the service (App., *infra*, 27a). The court concluded that "'[t]here can be no disputing the Secretary's statutory authority to define by regulation the method of computing [the reasonable charge]'" (*id.* at 21a, quoting *Fairfax Hospital Ass'n* v. *Califano*, 585 F.2d 602, 605 (4th Cir.

1978)). But the court nevertheless entered a preliminary injunction because of its concern that the Secretary had not followed the notice and comment procedures of the APA when he issued instructions to carriers regarding the calculation of the reasonable charge for CT scans (App., *infra*, 21a).

In its order entering the preliminary injunction, the district court concluded that it had jurisdiction over the case under 28 U.S.C. 1331 notwithstanding the third sentence of 42 U.S.C. 405(h),[3] which provides that "[n]o action" shall be brought against the Secretary under 28 U.S.C. 1331 "to recover on any claim arising under" the Medicare Act. The court reasoned that this Court's decision in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), holding that Section 405(h) bars the exercise of jurisdiction under 28 U.S.C. 1331 over any claim arising under the Social Security Act, is inapplicable where the claim is not otherwise reviewable under the Social Security Act (App., *infra*, 24a). The district court adhered to this view in a subsequent order dated April 16, 1982, but certified the question of subject matter jurisdiction for interlocutory appeal pursuant to 28 U.S.C. 1292(b) (App., *infra*, 39a-40a).

c. The court of appeals granted leave to appeal (C.A. App. 163) and affirmed the district court's jurisdictional ruling (App., *infra*, 1a-18a). The court of appeals recognized that this Court had held in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), that in view of the precisely drawn provisions for judicial review in 42 U.S.C. 1395ff and the legislative history of those provisions, Congress had foreclosed judicial review of a carrier's determination of the

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[3] As made applicable to the Medicare Program by 42 U.S.C. 1395ii.

amount of benefits payable under Part B for a particular service. App., *infra*, 7a. It further recognized that this preclusion of review applies even where the carrier's determination was based on instructions issued by the Secretary regarding the calculation of the reasonable charge, as in *Erika* itself. *Id.* at 9a. The court held, however, that although 42 U.S.C. 1395ff and the decision in *Erika* bar a judicial challenge to a *past* benefit determination, they do not bar a plaintiff from seeking *prospective* relief from the Secretary's actions in administering Part B through the issuance of such instructions. App., *infra*, 9a-10a.[4]

Similarly, the court of appeals concluded that 42 U.S.C. 405(h) does not preclude the exercise of jurisdiction under 28 U.S.C. 1331 over a challenge to a ruling by the Secretary that affects the amount of benefits payable under Part B where the ruling is alleged to violate the APA, the Medicare Act, or the Constitution, so long as the plaintiff does not actually seek an award of benefits from the district court. The court stated (App., *infra*, 15a (footnote omitted)):

> As we view plaintiffs' complaint, the gravamen of their action with respect to the alleged violation of [the] APA, the alleged violation of the

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[4] The court of appeals also concluded that 42 U.S.C. 1395ff and the decision in *Erika* do not bar judicial review of a carrier's decision on an individual benefit claim if that decision is challenged on constitutional grounds (App., *infra*, 9a-10a). However, the court rejected as "frivolous" one aspect of respondents' constitutional claim on the merits: that they had a constitutional right to notice and an opportunity to comment in connection with the promulgation of rules of general applicability. App., *infra*, 15a n.4 (citing *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519, 542 n.16 (1978)).

> Medicare Act and the alleged violation of their constitutional rights, is to redress those violations. Of course a well-founded complaint in that regard has a secondary effect on the benefits and payments due them. It may well be true that the effect of the preliminary injunction suspending enforcement of the caps granted by the district court entitles plaintiffs to be paid more than they would receive were the caps being enforced. But we do not perceive the suit [as] essentially one to recover benefits; it is a suit to enforce lawful conduct on the part of the Secretary. Cf. *Ringer v. Schweiker*, 684 F.2d 643, 646 (9 Cir. 1982).

The court of appeals acknowledged that in holding that the district court had jurisdiction under 28 U.S.C. 1331, it was deciding a "close case" and that a "higher reviewing court" might conclude that it had misconstrued 42 U.S.C. 405(h) and 1395ff (App., *infra*, 15a). But it determined that if Section 1331 does not provide jurisdiction, then respondents' challenge could be heard under the mandamus statute, 28 U.S.C. 1361. In the court's view, this conclusion was not contrary to the purpose of 42 U.S.C. 405(h), because that section was intended only to prevent circumvention of the express judicial review provisions in the Social Security Act itself and not to preclude all judicial review of determinations under the Act. The court found no inconsistency with Section 405(h) here because the Act does not provide for judicial review of benefit amount determinations under Part B of the Medicare Program. App., *infra*, 16a-17a.

REASONS FOR GRANTING THE PETITION

The decision of the court of appeals, holding that the district court had jurisdiction under 28 U.S.C. 1331 and 1361 to review respondents' challenge to benefit amount determinations under Part B of the

Medicare Act, is flatly inconsistent with this Court's rulings in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), and *Weinberger* v. *Salfi*, 422 U.S. 749 (1975). Moreover, the issues in this case are closely related to those presented in *Heckler* v. *Ringer*, cert. granted, No. 82-1772 (June 27, 1983). The petition therefore should be held pending the Court's decision in *Ringer*.

1. Respondents brought this suit to challenge the amount of benefits payable for CT scans under Part B of the Medicare Program as a result of the 1977 agency memoranda and the 1978 Intermediary Letter issued to carriers regarding the excessive charges for those services. As this Court held in *Erika*, however, Congress has foreclosed judicial review of the amount of benefits payable under Part B.

In 42 U.S.C. 1395ff(a), Congress provided that "the determination of the amount of benefits under part A [of the Medicare Program], shall be made by the Secretary in accordance with regulations prescribed by [her]." The Secretary is authorized to enter into contracts with fiscal intermediaries to make these initial determinations on her behalf. See 42 U.S.C. (& Supp. V) 1395h. An individual who is dissatisfied with the initial determination of the "amount of benefits under Part A" is entitled to an evidentiary hearing before an administrative law judge in HHS if the amount in controversy is $100 or more and to judicial review as provided in 42 U.S.C. 405(g) if the amount remaining in controversy on the particular claim after the hearing is $1,000 or more. 42 U.S.C. 1395ff(b)(1)(C) and (2). On judicial review under 42 U.S.C. 405(g), the individual may contend that he is entitled to receive a greater amount of benefits under Part A than was awarded at the administrative level because the Secretary relied upon an invalid regulation in her "final

decision" denying or limiting the amount of benefits. See *Weinberger* v. *Salfi*, 422 U.S. at 762.

Determinations and evidentiary hearings with respect to the amount of benefits on a particular claim under Part B are conducted by private insurance carriers under contract with the Secretary. As this Court noted in *Erika* (456 U.S. at 208), 42 U.S.C. 1395ff conspicuously fails to authorize judicial review of the "amount of benefits" under Part B, even though it expressly authorizes such review under Part A. In light of the statute's "precisely drawn provisions," the Court in *Erika* found this omission persuasive evidence that Congress had "deliberately * * * foreclosed" judicial review of benefit amount determinations under Part B. 456 U.S. at 208. The Court found this indication confirmed by the legislative history of Section 1395ff, which evidenced a congressional intent to remove from the courts what were expected to be relatively minor disputes over the amount of benefits under Part B. 456 U.S. at 208-210.

Moreover, as the court below recognized (App., *infra*, 8a-9a), this foreclosure of judicial review under Part B was intended to apply even where the plaintiff challenges an instruction issued by the Secretary that has the effect of limiting the amount of benefits payable on an individual claim. In *Erika* itself the plaintiff's claim to increased benefits was based in part on a challenge to instructions issued by the Secretary that limited the amount of benefits that could be awarded by the carrier. *Erika, Inc.* v. *United States*, 634 F.2d. 580, 589 (Ct. Cl. 1980). This conclusion also is evident from the structure of 42 U.S.C. 1395ff. Congress has authorized judicial review of the "amount of benefits under part A" and, as we have said, such review may include a challenge to regulations that establish benefit amounts or guide

fiscal intermediaries in computing those amounts. The corresponding foreclosure of judicial review of the amount of benefits under Part B accordingly must extend to challenges to instructions or regulations issued by the Secretary that have the effect of limiting the amount of benefits determined by a carrier. Yet the court of appeals would permit a beneficiary to avoid this foreclosure of review simply by filing a suit challenging the Secretary's directives that limit the amount of benefits payable on his Part B claim before he has received a final decision from the carrier on that claim. This result would largely vitiate the Court's unanimous holding in *Erika*.

Nor can respondents circumvent this preclusion of judicial review and the decision in *Erika* under the guise of seeking only "prospective relief" with respect to the amount payable on future claims under the Secretary's directives, rather than the reopening of carrier determinations on past claims (see App., *infra*, 7a-10a). Such a suit is still one seeking judicial review of the "amount of benefits," which 42 U.S.C. 1395ff authorizes in limited circumstances under Part A but not under Part B. Indeed, the court of appeals recognized that the effect of respondents' challenge to the Secretary's directives is to increase the amount of benefits awarded by the carrier (App., *infra*, 15a (quoted at pages 9-10, *supra*)), and respondents would need to have a claim for increased benefits in order to have standing and a substantive basis for their suit. See *Weinberger* v. *Salfi*, 422 U.S. at 760-761.

The legislative history relied upon by the Court in *Erika* does not suggest a less comprehensive foreclosure of judicial review under Part B than is indicated by the text of 42 U.S.C. 1395ff. 456 U.S. at 208-210.

To the contrary, the Conference Report on the 1972 amendments to 42 U.S.C. 1395ff states that those amendments were added to make clear that there is "no authorization * * * for judicial review on matters solely involving amounts of benefits under Part B" (H.R. Conf. Rep. 92-1605, 92d Cong., 2d Sess. 61 (1972)).[5] Respondents' attempt to obtain judicial review of agency directives setting limits on Part B benefit payments for particular services plainly is one "involving amounts of benefits under Part B" and therefore is inconsistent with this expression of congressional intent.

In this regard, the procedure Congress mandated for judicial review of benefit amount determinations under Part A is again significant. It is clear that a Medicare beneficiary cannot circumvent the terms of the Act that limit judicial review under Part A to suits brought pursuant to 42 U.S.C. 1395ff—which provides for review only after the Secretary has rendered a "final decision" on an individual claim and only if there is $1000 or more remaining in controversy—by confining his claim to "prospective" relief. It necessarily follows that a beneficiary cannot circumvent the *complete* foreclosure of judicial review under Part B in this manner.

2. The correctness of the result indicated by 42 U.S.C. 1395ff standing alone—that judicial review of the amount of benefits under Part B is foreclosed because it is not expressly authorized—is confirmed by

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[5] See also *Erika*, 456 U.S. at 208 (quoting S. Rep. 404, 89th Cong., 1st Sess. 55 (1965)) (the bill "did not provide for judicial review of 'a determination concerning the amount of benefits under [P]art B' "); 456 U.S. at 209 n.11 (quoting S. Rep. 404, *supra*, at 55 (emphasis added by the Court)) (" '*the remedies provided by* [*the statutory*] *review procedures* [*are*] *exclusive*' ").

42 U.S.C. 405(h).* The second sentence of Section 405(h) embodies a general rule under the Social Security Act that judicial review is unavailable except where and in the manner such review is expressly authorized under that Act. The second sentence provides that "[n]o findings of fact or decision by the Secretary shall be reviewed by any person, *tribunal*, or governmental agency *except as herein provided*" (emphasis added). Because carriers make determinations on claims for benefits under Part B on behalf of the Secretary (see *Schweiker* v. *McClure*, 456 U.S. at 190), this preclusion of review applies equally to findings and decisions by the carriers under Part B. Moreover, to the extent respondents' challenge is confined to the limitations on payment for CT scans contained in the 1977 agency memoranda and 1978 Intermediary Letter issued by the Secretary on the basis of factual studies of CT scans, respondents actually seek review in a judicial "tribunal" of "findings of fact or decision" of the *Secretary*, which is expressly barred by the second sentence of Section 405(h).

The third sentence of 42 U.S.C. 405(h) further provides that "[n]o action" shall be brought against the Secretary under 28 U.S.C. 1331 "to recover on any claim arising under" the Medicare Act. The court of appeals' holding that the district court had jurisdiction over this suit under 28 U.S.C. 1331 directly contravenes this jurisdictional bar as well. It is similar to the Ninth Circuit's holding in *Ringer* v. *Schweiker*, 684 F.2d 643 (1982), cert. granted, No. 82-1772 (June 27, 1983), that the third sentence of Section 405(h) does not bar jurisdiction under 28

* 42 U.S.C. 405(h) is made applicable to the Medicare Program by 42 U.S.C. 1395ii.

U.S.C. 1331 over a "procedural" challenge to a regulation prohibiting the payment of benefits for a particular medical procedure under the Medicare Program. In *Ringer*, as here, the respondents challenged the regulation on the grounds that it was promulgated in violation of the notice and comment requirements of the APA, was inconsistent with the Medicare Act, and violated the respondents' due process rights. See 82-1772 Pet. Br. 10.

We have argued in *Ringer* (82-1772 Pet. Br. 20-32[7]) that the Ninth Circuit's holding conflicts with this Court's decision in *Weinberger* v. *Salfi*, *supra*, that the "sweeping" bar in 42 U.S.C. 405(h) cannot be circumvented by characterizing the challenge as "procedural" or by seeking only prospective relief, that the preclusion of review in Section 405(h) applies even where the plaintiff does not seek an actual award of benefits in district court, and that the "APA" claim in fact arises under the Medicare Act rather than the APA and cannot in any event be brought under 28 U.S.C. 1331. Our submission in *Ringer* applies equally here. We therefore suggest that the Court hold the petition in this case pending a decision in *Ringer* regarding the scope of Section 405(h) and then dispose of the petition in light of that decision.

3. The court of appeals recognized that a "higher reviewing court" might disagree with its construction of 42 U.S.C. 1395ff and 405(h), and it therefore concluded that the district court also had jurisdiction

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[7] We have furnished respondents with a copy of our brief in *Ringer*.

over this case under the mandamus statute, 28 U.S.C. 1361 (App., *infra*, 15a-18a). The question of the existence of mandamus jurisdiction over claims arising under the Medicare Act is involved in *Ringer* as well, because the Ninth Circuit there held that the district court had jurisdiction under 28 U.S.C. 1361 over the respondents' "procedural" claims. 684 F.2d at 645-646, 648.

We have argued in *Ringer* (82-1772 Pet. Br. 32-36) that Section 405(h) bars mandamus jurisdiction over cases arising under the Medicare Act and that, in any event, the exercise of mandamus jurisdiction was precluded in that case because, inter alia, the Secretary did not owe the respondents a "clear duty" to act in the manner they sought to compel. Those arguments apply equally here to bar the exercise of mandamus jurisdiction.[8] This additional similarity between the two cases further indicates that the petition in this case should be held pending a decision in *Ringer*.

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[8] The Ninth Circuit appeared to be of the view in *Ringer* that whenever the bar in Section 405(h) does apply, it extends to mandamus jurisdiction as well as federal question jurisdiction. 684 F.2d at 645, 646 & n.2, 648. The court below, by contrast, believed that mandamus jurisdiction would lie even if federal question jurisdiction is barred. App., *infra*, 15a.

CONCLUSION

The petition for a writ of certiorari should be held pending the Court's decision in *Heckler* v. *Ringer*, No. 82-1772, and then be disposed of in light of that decision.

Respectfully submitted.

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JANUARY 1984

APPENDIX A

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT

No. 82-1543

EULA B. STARNES, JOHNNIE KAYE LLOYD, NETTIE E. CLARKSON, JAYNE E. DUNLAP, individually and on behalf of others similarly situated; JULIAN ADAMS, M.D., FRED H. ALLEN, JR., M.D., WILLIAM H. STUART, M.D., RHETT O. TALBERT, M.D., ATLANTA NEUROLOGICAL CLINIC, P.C., C.T. SCANLAB and TRIDENT NEUROIMAGING LABORATORY, individually and on behalf of others similarly situated, APPELLEES

v.

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, APPELLANT

and

PRUDENTIAL INSURANCE COMPANY OF AMERICA AND BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, INC., individually and on behalf of others similarly situated, DEFENDANTS

Argued Feb. 10, 1983

Decided Aug. 16, 1983

Before WINTER, Chief Judge, PHILLIPS, Circuit Judge, and MERHIGE,* District Judge.

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* Hon. Robert R. Merhige, Jr., United States District Judge for the Eastern District of Virginia, sitting by designation.

HARRISON L. WINTER, Chief Judge:

We granted leave to take this interlocutory appeal to settle the question of whether the district court had jurisdiction to decide procedural, substantive and constitutional challenges to benefit levels set by the Secretary of Health and Human Services to guide private insurance carrier benefit determinations under Part B of the Medicare statute. The district court ruled that it had jurisdiction. It exercised its jurisdiction, however, only to grant a preliminary injunction based upon a prima facie showing of a procedural deficiency in the manner in which the Secretary proceeded, reserving judgment on the substantive and constitutional challenges.

We conclude that the district court has jurisdiction either under 28 U.S.C. § 1331 or, under the mandamus statute, 28 U.S.C. § 1361. Accordingly, we affirm the judgment of the district court.

I.

Part B of the Medicare Program is a voluntary medical insurance program for the aged and disabled, funded by monthly premiums and contributions from general revenues of the federal government. Part B supplements the general coverage of Part A by insuring against some medical expenses not covered by the latter. Determinations of benefits paid for Part B coverage are made by private insurance carriers employed by the Secretary in accordance with regulations and policy guidelines issued by the Secretary. Persons to whom Part B is applicable are entitled to reimbursement of 80 percent of the "reasonable charge" for covered medical services, including physicians' services. 42 U.S.C. § 1395k. Under the Medicare Act, the Secretary's determinations as to

eligibility for benefits under Parts A and B are administratively reviewable, as are his determinations of benefits under Part A if the amount in controversy exceeds $100, with a right of judicial review. 42 U.S.C. § 1395ff. No determination of the amount of benefits under Part B is administratively or judicially reviewable. Once a carrier determines benefits owed to a claimant, they are actually paid out of a government trust fund.

Plaintiffs are (a) Medicare beneficiaries enrolled in Part B of the Medicare Program, and (b) physicians and clinics which provide computerized tomography ("CT") scans to the class of Medicare patients which the Medicare beneficiary plaintiffs represent. Plaintiffs brought this class action to challenge the establishment and implementation by the Secretary of nationwide and regional ceilings or caps on Part B reimbursements for CT head scans. Through several letters or memoranda the Secretary has established a national ceiling on reimbursement for such services. In June 1977, the Regional IV Office (Atlanta) sent letters to all Part B carriers in Region IV proposing that no more than $150 be paid for CT head scans. In December 1977 a memorandum was issued to all Regional Medicare Directors indicating that $150 was a reasonable charge for CT scans. In September 1978 the nationwide caps were adjusted by a letter issued to all insurance carriers which indicated that a reasonable charge for CT scans should range from $157.50 to $172.50, with the amount allowed in a particular case to depend upon whether contrast enhancement was used in the scan.

The named plaintiffs unsuccessfully exhausted their administrative remedies before bringing this action to challenge the directives. They appealed benefit determinations to carrier-appointed hearing offi-

cers, the only administrative remedy provided under the Act, 42 U.S.C. § 1395u(b)(3)(C), and they have informally petitioned the Secretary and the Regional Offices for relief from the caps. The Secretary and his subordinates have been steadfast in enforcing the caps, although the Secretary's counsel advised that the Secretary should proceed in accordance with the Administrative Procedure Act and "make a case in the rulemaking record" why the caps selected are reasonable.

Plaintiffs challenge the cap on a number of grounds. They contend that the Secretary's informal letters, directives and memoranda establishing the caps constitute rulemaking without notice and opportunity for comment, in violation of the Administrative Procedure Act. 5 U.S.C. § 553(b). They contend that the caps violated their equal protection and due process rights by depriving them of property rights without notice or opportunity for comment and by arbitrarily and unreasonably imposing a different standard for the determination of CT scan benefits than is used for the determination of other Part B benefits. They contend that the caps are inconsistent with the Medicare Act's requirements that carriers, and not the Agency, determine the reasonableness of charges on which benefits to be paid to claimants are computed. And, they assert that the caps violate the requirement that the customary and prevailing charge be paid for Part B services. They seek an injunction against enforcement and implementation of the caps and a direction to the Secretary that she withdraw the caps, advise all Part B carriers of their withdrawal and require all carriers who have applied the caps to recompute claims and make additional payments with interest where indicated. As supplemental relief plaintiffs request costs and attorneys' fees.

On March 6, 1980, the district court ruled that it had jurisdiction over all of plaintiffs' claims, concluded the caps were promulgated in violation of the APA's rulemaking requirements, and preliminarily enjoined their implementation nationwide until regulations authorizing such caps were properly promulgated. The district court reaffirmed its jurisdictional holding on April 16, 1982, reserving ruling on plaintiffs' other contentions, and certified the question for appeal to this court. We granted leave to maintain it.

II.

Plaintiffs allege jurisdiction in the district court by virtue of 28 U.S.C. § 1331 (federal question jurisdiction), § 1346 (suits against the United States involving federal questions), and § 1361 (mandamus jurisdiction). They also allege jurisdiction under 5 U.S.C. §§ 701-706, the Administrative Procedure Act, but it is well-settled that that Act contains no independent grant of jurisdiction. *See Califano v. Sanders*, 430 U.S. 99, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977). Thus we consider, first, if there is federal question jurisdiction, and, second, if there is jurisdiction to grant a writ of mandamus. The Secretary argues that federal court jurisdiction is barred by two provisions of the Medicare Act, 42 U.S.C. § 1395ff and 42 U.S.C. § 1395ii. We discuss them seriatim.

A. 42 U.S.C. § 1395ff

As we have previously described, § 1395ff provides that the Secretary shall determine eligibility for the Part A and Part B programs and benefit amounts for the Part A program, and that judicial review of these determinations may be had pursuant to 42 U.S.C. § 405(g). It does not, however, empower the Secre-

tary to determine benefit amounts under the Part B program, nor does it provide for judicial review of carrier determinations.[1] Instead, Part B benefit de-

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[1] Section 1395ff provides:

(a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) (1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be avaliable to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

terminations are made by private insurance carriers and are appealable only to carrier-appointed hearing officers. 42 U.S.C. § 1395u.

In two recent cases, the Supreme Court has addressed this scheme. In *United States v. Erika*, 456 U.S. 201, 102 S.Ct. 1650, 72 L.Ed.2d 12 (1982), it held that § 1395ff forbade judicial review of Part B benefit amount determinations made by carriers. And, in *Schweiker v. McClure*, 456 U.S. 188, 102 S.Ct. 1665, 72 L.Ed.2d 1 (1982), it found no due process violation in the use of carrier-appointed hearing officers to resolve disputes over benefit amounts and in the denial of a right to de novo administrative review of their determinations.

We find nothing in the language of § 1395ff nor in the Supreme Court's opinion in *Erika* to suggest that the Secretary's administration of the Part B program, as distinguished from the correctness of benefit determinations thereunder, should not be subject to judicial oversight. The language of § 1395ff indicates that Congress sought to preserve judicial review of actions taken by the Secretary, but not actions taken by private carriers. Section 1395ff renders reviewable those actions to be performed by the Secretary —Part A benefit amount determinations and Part A and Part B eligibility determinations—while those actions which are delegated to private carriers—Part B benefit amount determinations—are made unreviewable. In the discussion of the section in the Act's legislative history, only benefit amount determinations are said to be unreviewable, and in each instance it is also noted that private carriers, and not the Secretary, are responsible for those determinations.[2]

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[2] The Senate Report stated: "Under the supplementary plan, carriers, not the Secretary, would review beneficiary

Erika held that particular carrier benefit determinations are unappealable. The Court phrased the question presented there as whether there is "jurisdiction to review determinations by private insurance carriers of the amount of benefits payable under Part B of the Medicare statute." 456 U.S. at 205-208, 102 S.Ct. at 1653-1654, 72 L.Ed.2d at 17-18. And it agreed with the position that the United States had taken in the case that "Congress, by enacting the Medicare statute . . . specifically precluded review in the Court of Claims of adverse hearing officer determinations of the amount of Part B payments." 456 U.S. at 206-207, 102 S.Ct. at 1653-1654, 72 L.Ed.2d at 17-18. Moreover, *McClure* suggests that some degree of judicial oversight of the Part B program is preserved, despite § 1395ff, for the Supreme Court assumed without discussion that it possessed jurisdiction to hear a constitutional challenge to the benefit determination procedures provided by Congress.

Erika does, however, compel the conclusion that a plaintiff cannot seek to reopen a benefit determina-

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complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A." S.Rep. No. 404, 89th Cong., 1st Sess., [1965] U.S.Code Cong. & Admin.News 1943, 1975. When § 1395ff(b) was amended in 1972, Congress re-emphasized the absence of judicial review on Part B determinations, again noting the Secretary was not responsible for these decisions. The House Report on the amendments stated: "There is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B . . ." H.R. Rep. No. 92-1605, 92d Cong.2d Sess. 61 (1972), U.S.Code Cong. & Admin.News 1972, pp. 5370, 5394. From this, we discern that Congress unmistakably intended that carrier determinations be unreviewable.

tion by challenging a regulation or some other action by the Secretary which influenced it. The suit in *Erika* was brought by a distributor of kidney dialysis supplies to challenge the implementation by an insurance carrier of a regulation defining the reasonable charge for a service on the basis of its price in the year prior to the year in which the service was rendered. The Court of Claims concluded that the regulation was invalid, and directed the carrier to recalculate benefits owed to the plaintiff by some more accurate method. *Erika, Inc.* v. *United States*, 634 F.2d 580, 589 (Ct.Cl. 1980). In finding the Court of Claims to be without jurisdiction, then, the Supreme Court implicitly held that a carrier benefit determination could not be reopened even though it was alleged to be unlawful because of some action by the Secretary.

McClure, however, strongly suggests that a benefit determination may be reviewed and reopened when the alleged infirmity is constitutional in nature. In that case the Supreme Court both assumed that it possessed jurisdiction over a due process challenge to the procedures followed in prior determinations and left open the door to future constitutional challenges to benefit determinations when it could be proven that the carrier-appointed hearing officer was biased. 456 U.S. at 195-198, 102 S.Ct. at 1670-1671, 72 L.Ed.2d at 8-9. The issue was not addressed in *Erika*, for while a constitutional claim had been made below it was held to be insubstantial and was not pressed before the Supreme Court. 456 U.S. at 206 n. 5, 102 S.Ct. at 1653 n. 5, 72 L.Ed.2d at 17 n. 5.

Prior to *Erika* there was universal agreement that actions by the Secretary and even private carriers could be assailed on constitutional grounds in either a district court, *Kechijian v. Califano*, 621 F.2d 1 (1

Cir. 1980); *Pushkin v. Califano*, 600 F.2d 486 (5 Cir. 1979); *Cervoni v. Secretary of Health, Ed. & Welfare*, 581 F.2d 1010 (1 Cir. 1978); *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283 (8 Cir.) *cert. den. sub nom. Faith Hospital Assoc. v. Blue Cross Hosp. Serv., Inc.*, 429 U.S. 977, 97 S.Ct. 484, 50 L.Ed.2d 584 (1976), or the Court of Claims, *Bussey v. Harris*, 611 F.2d 1001 (5 Cir. 1980); *Drennan v. Harris*, 606 F.2d 846 (9 Cir. 1979). We see no reason to depart from this position for there is no indication in the Act's legislative history that Congress intended a result so drastic as, by the enactment of § 1395ff, to preclude judicial enforcement of the Constitution with respect to the administration of the Part B Program of Medicare. Thus to immunize the Secretary and the carriers from the Constitution's mandate would raise a constitutional question of the gravest sort, and we decline to adopt such an interpretation unless that is clearly the will of Congress. *See Weinberger v. Salfi*, 422 U.S. 749, 762, 95 S.Ct. 2457, 2465, 45 L.Ed.2d 522 (1975); *Johnson v. Robison*, 415 U.S. 361, 366-367, 373, 94 S.Ct. 1160, 1165-1166, 1168, 39 L.Ed.2d 389 (1974).

In sum, we hold § 1395ff does not restrict whatever right the plaintiffs may have to seek prospective relief from the Secretary's actions, but that it does bar the reopening of past benefit determinations on other than constitutional grounds.

B. 42 U.S.C. § 1395ii

Federal question jurisdiction would undoubtedly exist but for the possible bar of 42 U.S.C. § 1395ii which incorporates 42 U.S.C. § 405(h) into the Medicare Act. Specifically, § 1395ii states that "(t)he provisions . . . of subsection . . . (h) . . . of Section

405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter." Section 405(h), thus made applicable, states:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

The precise meaning and scope of § 405(h) has been the subject of a large and ever-expanding body of case-law. *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), is the first and most significant authority. There the Supreme Court held that a constitutional challenge to a duration of relationship requirement of the Social Security Act was a claim "arising under" the Act, which § 405(h) removed from federal question jurisdiction under 28 U.S.C. §§ 1331 and 1346. In reaching this result, the Court interpreted § 405(h) literally, to bar use of § 1331 as a jurisdictional basis for any claim arising under the Social Security Act. *Id.* at 757, 95 S.Ct. at 2462. It found that the challenge to the Act's duration of relationship eligibility requirement did arise under the Act since the plaintiffs ultimately sought to recover Social Security benefits and the Act provided them with "both the standing and the substantive basis for the presentation of their constitutional claims." *Id.* at 760-761, 95 S.Ct. at 2464-2465.

Perhaps significantly, the Act did provide another mechanism for raising the question, and the Court ruled that jurisdiction existed to review the individual plaintiff's claim under 405(g). *Id.* at 763-767, 95 S.Ct. at 2465-2467.

Since *Salfi* the Supreme Court has had occasion to discuss § 405(h) in several other cases. Generally, the Court has held it to bar use of § 1331 as a jurisdictional basis for Social Security Act claims while expanding the possibilities for judicial review and relief under § 405(g). Thus, in *Mathews v. Eldridge*, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976), the Court held that a due process challenge to disability benefit termination procedures was a claim "arising under" the Act which could only be presented under § 405(g). But, it sustained jurisdiction over Eldridge's claim by interpreting the exhaustion requirement of that section to be waivable so long as a claim for benefits was submitted to the Secretary. In *Norton v. Mathews*, 427 U.S. 524, 96 S.Ct. 2771, 49 L.Ed.2d 672 (1976), it deemed a constitutional challenge brought by an illegitimate child to a certain dependency provisions to be so insubstantial that it could be rejected on the merits without deciding whether there was jurisdiction over the case. In *Califano v. Sanders*, *supra*, it held the APA was not an independent jurisdictional basis for claims arising under the Social Security Act. In *Califano v. Yamasaki*, 442 U.S. 682, 689, 99 S.Ct. 2545, 2551, 61 L.Ed. 2d 176 (1979), it held that class actions and nationwide injunctive relief were permissible under § 405 (g). In *Schweiker v. McClure*, 456 U.S. 188, 102 S.Ct. 1665, 72 L.Ed.2d 1 (1982), the Court assumed, without discussion, that it possessed jurisdiction over a constitutional challenge to benefit determination

procedures. Finally, in *United States v. Erika*, 456 U.S. 201, 102 S.Ct. 1650, 72 L.Ed.2d 12 (1982), it held that § 1395ff of the Act barred appeals of Part B benefit determinations, and did not consider § 405(h).

Plaintiffs argue that these precedents do not foreclose their contention that § 1331 jurisdiction exists to redress the Secretary's violation of APA, and we agree. There is persuasive authority for that proposition and we conclude to follow it.[8] *See, e.g., National Association of Home Health Agencies v. Schweiker*, 690 F.2d 932 (D.C. Cir. 1982); *Daniel Freeman Memorial Hosp. v. Schweiker*, 656 F.2d 473 (9 Cir. 1981); *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070, 1080 (D.C. Cir. 1978); *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283, 291-294 (8 Cir.); *cert. den. sub nom. Faith Hosp. Ass'n v. Blue Cross Hosp. Serv., Inc.*, 429 U.S. 977, 97 S.Ct. 484, 50 L.Ed.2d 584 (1976). *But see Hadley Memorial Hosp., Inc. v. Schweiker*, 689 F.2d 905, 910-12

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[8] Both in *Mathews v. Eldridge*, 424 U.S. 319, 327, 96 S.Ct. 893, 899, 47 L.Ed.2d 18 (1976) and *Califano v. Sanders*, 430 U.S. 99, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977), it was assumed that a due process challenge to benefit termination procedures, and a challenge to the Secretary's refusal to reopen a disability determination, respectively, were barred by § 405(h). We cannot read either case as a square holding to that effect, especially since the claimant in *Mathews* had sought a reinstatement of benefits as an inseparable part of his procedural claim. *See Humana*, 590 F.2d at 1080-81 n. 76. We also note *Hopewell Nursing Home, Inc. v. Schweiker*, 666 F.2d 34, 39 (4 Cir. 1981). There we held that a claim fell within the scope of § 405(h), even though the requested relief was an order that benefits be recomputed and not necessarily increased, since the plaintiff's ultimate objective, in fact, was to increase its benefits. In that case the plaintiff had made several procedural claims in the district court, but they were not pressed on appeal and we did not rule on them.

(10 Cir. 1982). These cases limit the bar of § 405(h) to claims brought to recover benefits and permit the exercise of § 1331 jurisdiction to adjudicate any other right for which no alternative form of judicial relief is available.

The *Home Health Agencies* case is one of the most persuasive in this line of authorities. It is also one of the latest and it collects all of the pertinent authorities extant at the time it was decided. There, numerous home health agencies and a trade association attacked the validity of regulations requiring home health agencies to seek medicare reimbursement determinations and payment from government-designated regional intermediaries. Because there was no statutory right of judicial review, they sought to invoke federal question jurisdiction to adjudicate their claims that the Secretary had illegally violated the Medicare Act, the APA and denied them due process in promulgating the regulation. As to the jurisdictional issue, the court of appeals held that, in the absence of a statutory right of judicial review, the district court had federal question jurisdiction to decide the issue on their merits, and, moreover, the lack of a statutory right of judicial review did not evidence congressional intent to deny federal question jurisdiction. It stressed that there was not legislative history to indicate that, by the enactment of § 405(h), Congress intended to preclude federal question jurisdiction other than in those instances when an alternative statutory right of judicial review had been established, and that the exercise of federal question jurisdiction was not counter to the purpose of § 405(h). Finally it ruled that the fact that Congress had provided for a statutory right of review in other instances did not overcome the general presumption in favor of judicial review.

As we view plaintiffs' complaint, the gravamen of their action with respect to the alleged violation of APA, the alleged violation of the Medicare Act and the alleged violation of their constitutional rights,[4] is to redress those violations. Of course a well-founded complaint in that regard has a secondary effect on the benefits and payments due them. It may well be true that the effect of the preliminary injunction suspending enforcement of the caps granted by the district court entitles plaintiffs to be paid more than they would receive were the caps being enforced. But we do not perceive the suit essentially one to recover benefits; it is a suit to enforce lawful conduct on the part of the Secretary. *Cf. Ringer v. Schweiker*, 684 F.2d 643, 646 (9 Cir. 1982). We hold therefore that federal question jurisdiction existed in the district court.

III.

We recognize that, in deciding that federal question jurisdiction exists to litigate plaintiffs' procedural challenge, we decide a close case. It may well be that a higher reviewing court may be of the opinion that we have misconstrued §§ 1395ff or 405(h) or the authorities which have considered them. But if there is not federal question jurisdiction to decide plaintiffs' challenges, then we think that there is mandamus jurisdiction under 28 U.S.C. § 1361 to do so.

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[4] The allegation that there is a constitutional right to notice and opportunity to comment when an agency makes rules of general applicability is frivolous. It presents no substantial procedural constitutional claim. *See, e.g., Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, Inc.*, 435 U.S. 519, 542 n. 16, 98 S.Ct. 1197, 1211 n. 16, 55 L.Ed.2d 460 (1978).

The federal mandamus statute, added by the Mandamus and Venue Act of 1962, provides an independent grant of jurisdiction to compel an officer or employee of the United States to perform a duty owed to the plaintiff. *See* 28 U.S.C. § 1361. As collected in *Ellis v. Blum*, 643 F.2d 68, 78-82 (2 Cir. 1981), there is an impressive array of cases holding that § 1361 provides a jurisdictional basis to review procedures employed in administering social security benefits.[5] Three, *Ellis v. Blum*, *supra*, *White v. Mathews*, 559 F.2d 852, 856 (2 Cir. 1977), *cert. denied*, 435 U.S. 908, 98 S.Ct. 1458, 55 L.Ed.2d 500 (1978); and *Barnett v. Califano*, 580 F.2d 28 (2 Cir. 1978), have held that § 405(h) does not preclude mandamus jurisdiction to review the Secretary's procedures in disability cases. They reason that § 1361 does not come within the literal scope of § 405(h) either as it currently stands—it refers only to sections 1331 and 1346—or as it was originally enacted —it then forbade utilization of all jurisdictional provisions contained in section 41 of Title 28, but mandamus jurisdiction at that time was vested solely in the District of Columbia by virtue of the Act of February 27, 1802, 2 Stat. 103. Moreover, they note that preserving mandamus jurisdiction is not contrary to

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[5] The Supreme Court has left open the question whether § 405(h) prohibits reliance on § 1361 as a jurisdictional basis for cases arising under the Social Security Act. *Califano v. Yamasaki*, 442 U.S. at 697-698, 99 S.Ct. at 2555-2556; *Norton v. Mathews*, 427 U.S. at 529-530, 96 S.Ct. at 2774-2775. *Mathews v. Eldridge*, 424 U.S. at 332 n. 12, 96 S.Ct. at 901 n. 12. *But see Califano v. Sanders*, 430 U.S. at 111, 97 S.Ct. at 987 (Burger, C.J., and Stewart, J., concurring) (§ 405(h) limits jurisdiction to claims properly brought under § 405(g)).

the purpose of § 405(h), which is to prevent circumvention of the jurisdictional provisions provided by the Medicare Act, since it will only lie if no other remedy is available to the plaintiff.

We think that these holdings are applicable here. We held in *Burnett v. Tolson*, 474 F.2d 877 (4 Cir. 1973), that mandamus will lie when there is (a) a clear right on the part of the plaintiffs to the relief sought, (b) a clear duty on the part of the defendant to do the act in question, and (c) no other adequate remedy available. These conditions may all be met here, the third being met if we are incorrect in our conclusion that jurisdiction under § 1331 lies, notwithstanding § 405(h). Certainly the third condition is also met because plaintiffs have exhausted all administrative remedies available to them as well as having unsuccessfully pursued some informal extra-judicial ones.[6]

Even if jurisdiction rests solely on § 1361, we think that the grant of interim injunctive relief was proper. Mandamus jurisdiction under § 1361 permits flexible remedies, including injunctive or declaratory relief.

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[6] This conclusion does not conflict with our earlier decision in *Hopewell Nursing Home, Inc. v. Schweiker*, 666 F.2d 34 (4th Cir. 1981). In that case, we held that mandamus jurisdiction did not lie because the second condition was not met; it was "difficult to imagine how the Secretary could have failed to perform a duty owed the providers—*i.e.*, granting them a final decision on their claims—when they have not given him an opportunity to do so by availing themselves of the administrative process." *Id.* at 42. We thus indicated that mandamus jurisdiction was unavailable to those plaintiffs who failed to exhaust administrative remedies, absent a showing that the Secretary frustrated exhaustion by failing to act on the plaintiff's administrative claims. The named plaintiffs here, however, have exhausted their administrative remedies.

Crawford v. Cushman, 531 F.2d 1114, 1126 (2 Cir. 1976); *Burnett v. Tolson, supra*, 474 F.2d at 883. Although the question is relatively novel, we see no reason why a preliminary injunction should not also be available in an appropriate case, and in one case reported, preliminary relief was awarded on the basis of mandamus jurisdiction. *See Dull Knife v. Morton*, 394 F.Supp. 1299 (D.S.D. 1975). That the preliminary injunction may have the effect of increasing benefit payments for CT head scans until the caps are properly promulgated is no objection to its issuance. A court acting under mandamus jurisdiction may compel the payment of benefits by the government. *See, e.g., White v. Mathews, supra; Nat'l Treasury Employees Union v. Nixon*, 492 F.2d 587 (D.C. Cir. 1974). We express no view, however, as to whether the district court may also compel the retroactive payment of increased benefits. That issue is not yet before us because the district court only barred the implementation of the caps prospectively. *Cf. Nat'l Treasury Employees Union v. Nixon, supra* (retroactive pay increase may be ordered); *De Lao* v. *Califano*, 560 F.2d 1384 (9 Cir. 1977) (doctrine of sovereign immunity bars retroactive order).

AFFIRMED.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 82-1543

EULA B. STARNES, JOHNNIE KAYE LLOYD, NETTIE E. CLARKSON, JAYNE E. DUNLAP, individually and on behalf of other similarly situated; JULIAN ADAMS, M.D., FRED H. ALLEN, JR., M.D., WILLIAM H. STUART, M.D., RHETT O. TALBERT, M.D., ATLANTA NEUROLOGICAL CLINIC, P.C., C.T. SCANLAB and TRIDENT NEUROIMAGING LABORATORY, individually and on behalf of others similarly situated, APPELLEES

v.

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, APPELLANT

and

PRUDENTIAL INSURANCE COMPANY OF AMERICA and BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, INC., individually and on behalf of others similarly situated, DEFENDANTS

Appeal from the United States [District] Court for the District of South Carolina

This cause came on to be heard on the record from the United States District Court for the District of South Carolina, and was argued by counsel.

On consideration whereof, It is now here ordered and adjudged by this Court that the judgment of said District Court appealed from, in this cause, be, and the same is hereby, affirmed.

/s/ William K. Slate II
Clerk

[Filed Aug. 16, 1983]

APPENDIX C

IN THE DISTRICT COURT
OF THE UNITED STATES
FOR THE DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

Civil Action No. 79-2311-6

EULA B. STARNES, ET AL., PLAINTIFFS

—versus—

PATRICIA R. HARRIS, Secretary of Health, Education and Welfare, ET AL., DEFENDANTS

ORDER

This matter came on to be heard upon plaintiffs' verified Complaint and Application for a Temporary Restraining Order. Instead of issuing a Temporary Restraining Order on an *ex parte* basis, the court held a hearing on December 11, 1979, to consider a Preliminary Injunction against defendant's alleged improper implementation of ceilngs ("caps") on reimbursement for computerized tomography head scans (hereinafter "CT head scans") under Part B of the Medicare Program. The plaintiffs are Medicare beneficaries and physicians and physician-directed clinics which provide CT head scan services to Part B beneficiaries. Class action certification has not yet been granted to the purported plaintiff classes or to the purported defendant class. The plaintiffs challenge the alleged reimbursement caps on various substantive and procedural grounds, including the contention that the Secretary of Health, Education and Welfare (hereinafter "HEW") has imposed reimbursement caps without complying with the requirements of the

Administrative Procedure Act (hereinafter "APA"), 5 U.S.C. §§ 551-59 and 701-06.

"There can be no disputing the Secretary's statutory authority to define by regulation the method of computing 'reasonable cost' for charges for which a provider . . . seeks reimbursement under the Medicare program, nor the power of Congress to clothe the Secretary with the power to exercise that authority." *Fairfax Hospital Ass'n. v. Califano*, 585 F.2d 602, 605-06 (4th Cir. 1978). Even so, it is equally clear that such authority must be properly exercised.[1]

During the December hearing, the court became concerned that, as conceded by HEW, the alleged reimbursement caps had not been formulated in accordance with APA requirements despite an opinion from HEW's Office of General Counsel that, in order to properly establish such caps, HEW "will have to (1) proceed by rulemaking rather than by intermediary letter and (2) make a case in the rulemaking record for why the caps selected are reasonable." Complaint, Exhibit D, Letter from Galen Powers, HEW Assistant General Counsel to Robert Derzon, Administrator of HEW Health Care Financing and Human Development Services Division (Aug. 16, 1978). In support of its conclusion, the opinion letter cited the "substantial impact" test developed by some courts in assessing the necessity for following rulemaking procedure. *See Pickus v. United States Board of Parole*, 507 F.2d 1107 (D.C. Cir. 1974). It went on to analogize the instant issues to those considered in *Schupak v. Mathews*, MEDICARE AND MEDICAID

[1] While HEW's rulemaking activity on benefits questions was exempt from Administrative Procedure Act requirements before 1971, during that year the Secretary waived the exemption and submitted to the Act's provisions. 36 Fed.Reg. 2532 (1971).

GUIDE (CCH) ¶ 27,987 (D.D.C. Sept. 17, 1976), in which an ESRD formula which controlled reimbursements paid to dialysis facilities was held invalid because it had not been imposed pursuant to proper rulemaking procedure under the APA. The opinion letter noted that although the invalidation order in *Schupak* had been stayed until HEW had an opportunity to promulgate a formula by regulation, other courts have invalidated HEW regulations on procedural grounds without granting such stays. *See National Welfare Rights Organization v. Mathews*, 533 F.2d 637 (D.C. Cir. 1976); *Maryland v. Mathews*, 415 F.Supp. 1206 (D.D.C. 1976). Finally, the opinion letter suggested that "there is a very good possibility (especially considering that the Department received fair warning in the *Schupak* case) that a court would not stay its invalidation of an intermediary letter that purported to establish [caps on reimbursement] for CT scans."

In its Memorandum opposing injunctive relief, HEW contends that its Intermediary Letter 78-38 (Complaint, Exhibit C) is not inconsistent with its own counsel's opinion letter because it does not impose a cap on CT scan reimbursement, but only "provides direction and guidance to carriers as to how they should proceed when applying the reasonable charge methodology to develop screens for new and costly medical services and diagnostic procedures, such as CT scans." This quotation, taken from the Intermediary Letter itself, is followed by HEW's additional statement that "in this intermediary letter . . . we have provided our own conclusions as to appropriate reasonable charge limitations for these services."

While HEW attempts to distinguish the two, this court concludes that the intent and effect of Inter-

mediary Letter 78-38 is substantially the same as that of a more explicit and less artfully worded cap on reimbursement. Indeed, while on page 9 of its Memorandum HEW makes the above-mentioned denial that any cap was imposed, on page 10 of the same Memorandum, HEW complains that plaintiffs "bring this action more than two years *after imposition of the cap* . . . ." (emphasis added).

Despite its serious reservations about the procedural validity of HEW's action, the court withheld entry of a preliminary injunction, because defendants' counsel at the December hearing indicated that HEW was in the process of developing proposed regulations which would authorize HEW to set specific reimbursement caps for a variety of medical services, including CT head scans, and that HEW expected to submit those proposals to proper APA rulemaking process in the near future. Based upon these representations, the court directed HEW's counsel to submit a clarification of the scope of the proposed regulations and the anticipated time schedule for rulemaking.

On December 18, 1979, HEW submitted its Report, which set out a target date of October 1980, for publication of a final regulation. The Report gave no assurance that publication would be achieved even by October 1980. Instead, it conditioned the proposed schedule upon internal approvals of drafts of the proposed regulations. Contrary to the court's impression from the December hearing, it appears that the proposed regulation has not already been through the draft and approval process.

The court afforded the parties an opportunity to request a second hearing prior to its ruling, but no party sought an additional hearing.

Therefore, from the submissions of record, the December hearing and the applicable law, the court concludes as follows:

1. That this court has subject matter jurisdiction in this action under 28 U.S.C. § 1331 and the reasoning enunciated in *Hopewell Nursing Home, Inc. v. Califano*, MEDICARE AND MEDICAID GUIDE (CCH) ¶ 28,718 (D.S.C. Dec. 20, 1977). This court cleaves to its previous conclusion that *Weinberger v. Salfi*, 422 U.S. 749 (1975), and 42 U.S.C. § 405(h), do not preclude judicial review where the claims presented are not otherwise reviewable. *See Whitecliff, Inc. v. United States*, 536 F.2d 347, (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977).

2. There are no administrative remedies to be exhausted in the plaintiffs' procedural challenge to the promulgation of the CT reimbursement caps.

The court expresses no opinion at this time on the separate issue of exhaustion of administrative remedies by the plaintiffs under the substantive (*i.e.*, non-procedural) challenges asserted in the Complaint. *See Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978) (recognizing that exhaustion requirements may differ, depending, *inter alia*, upon the procedural or substantive nature of the challenge and that substantive challenges to the amount of cost reimbursement due a provider for accounting periods ending on or after June 30, 1973, require exhaustion of administrative remedies by submission to the Provider Reimbursement Review Board before institution of suit in federal district court).

3. That defendant Harris, her predecessor as Secretary of HEW, their agents, representatives, and employees have, since December, 1977, established, authorized, and approved the implementation of a

nationwide cap on reasonable charge reimbursement under Part B of the Medicare program for CT head scanning services and, since July 1, 1977, prior to the implementation of the nationwide ceiling, have established, authorized, and approved the implementation of a similar cap in Region IV of the Medicare Bureau.

4. That defendants Prudential Insurance Company of America, Blue Cross and Blue Shield of South Carolina, Inc., and other local "carriers" for Part B of the Medicare program have, acting in concert with defendant Harris, her predecessor in office, their agents, representatives, and employees, implemented the Region IV and nationwide reimbursement cap.

5. That the Region IV and nationwide reimbursement cap are lower than the customary and prevailing charges of physicians and physician-directed clinics for CT head scans.

6. That the authorization, direction, and implementation of said cap on Medicare reimbursement for CT head scanning services appear to be illegal and unauthorized in that such actions, having been taken without notice and opportunity to comment upon them and without a statement of their basis and purpose based upon such comments by interested persons, constitute improper rulemaking in violation of the Administrative Procedure Act.

7. That defendant Harris and her subordinates, the defendant carriers, and other members of the purported class of carriers under Part B will continue to implement the nationwide cap unless restrained by Order of this court.

8. That immediate and irreparable harm, injury, and damage will result to plaintiffs and to the public before a trial can be conducted on plaintiffs' prayer for a permanent injunction in that

(a) many members of the purported class of Medicare beneficiaries who desire and need CT head scan services but cannot afford to obtain such services from a physician or physician-directed clinic whose services are subject to the cap will be forced to seek such services, if at all, from hospitals not subject to the nationwide cap, even though the nearest hospital possessing a CT scanner may be less accessible and less convenient to said individuals and they may not receive the same quality of care. As a result, said Medicare beneficiaries will be deprived of the freedom of choice guaranteed to them by Congress to secure quality medical services from any qualified physician or institution of their choosing;

(b) members of the purported class of physicians and physician-directed clinics will be discouraged, contrary to the policy of the Medicare law, from accepting assignments from potential Medicare patients. As a result, their reputations will be damaged among their Medicare patients and within their communities, and many potential Medicare patients will be forced to seek CT head scan services, if at all, from competing hospitals possessing CT scanners. Said physicians and physician-directed clinics will suffer monetary losses, the amount of which may not be capable of exact determination; and

(c) the cost of the Medicare program to the public may be increased substantially because Medicare beneficiaries who have sought CT head scan services from physicians or physician-directed clinics having CT scanner facilities but for the nationwide cap, will secure such services from hospitals which possess CT scanners. The

additional cost to the public for providing CT services to a Medicare beneficiary in a hospital setting, rather than in a physician-directed office or clinic, may be substantial.

9. That greater injury will be inflicted upon plaintiffs and other members of the purported class of Medicare beneficiaries and the purported class of physicians and physician-directed clinics adversely affected by the nationwide cap by the denial of the relief requested by plaintiffs than will result to defendant Harris, the defendant carriers, and other members of the purported class of carriers under Part B by the granting of said relief.

10. That the public interest will be served by the granting of the relief requested by plaintiffs.

IT IS THEREFORE ORDERED that defendant Harris, her agents, representatives, and employees, and other acting in concert with them including defendant carriers and other members of the purported class constituted by all carriers under Part B of the Medicare program, be and they hereby are enjoined from authorizing, directing, recomending, acquiescing in, approving, and implementing any caps under Part B on CT head scan reimbursement which are inconsistent and in conflict with the criteria which were applied by carriers in making reasonable charge determinations for CT head scan services before ceilings were established by the Medicare program.

This preliminary injunction shall continue until such time, if any, as the Secretary may lawfully promulgate regulations authorizing HEW to set specific reimbursement caps for CT head scan services or until further Order of this court.

It is further ORDERED that plaintiffs shall give security in the sum of $5,000.00 for the payment of

such costs and damages as may be incurred or suffered by any party, or parties, who may be found to have been wrongfully enjoined or restrained.

AND IT IS SO ORDERED.

/s/ Charles E. Simons, Jr.
CHARLES E. SIMONS, JR.
United States District Judge

Columbia, S.C.

March 4th, 1980.

APPENDIX D

IN THE DISTRICT COURT
OF THE UNITED STATES
FOR THE DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

Civil Action No. 79-2311-6

EULA B. STARNES, ET AL., PLAINTIFFS

—versus—

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, ET AL., DEFENDANTS

This matter comes before the court upon the Motion of defendant Blue Cross and Blue Shield of South Carolina, Inc. ("BCBS"), for Summary Judgment or for an Order dropping the defendant BCBS as a party defendant. In the alternative, BCBS has moved for an Order severing the claim against it from the claims asserted against other defendants. Subsequently, the defendant Secretary of Health and Human Services (the "Secretary") moved the court to dismiss Prudential Insurance Company of America and BCBS as defendants in this action.

Plaintiffs have opposed these motions on the grounds that, under the circumstances of this case, the Part B Medicare carriers are proper parties defendant whose presence is necessary to insure full and adequate relief and that an independent claim has been asserted against BCBS and other similarly situated Medicare carriers.

Having considered the written motions of defendants and responses of plaintiffs and the argments made by counsel for both sides in a hearing before this court, the Motion of BCBS for Summary Judgment or for an Order dropping BCBS, or, in the

alternative, for an Order severing the claim asserted against BCBS is denied. The Secretary's Motion to Dismiss is also denied.

Also before the court is plaintiffs' Motion for a determination under Fed. R. Civ. P. 23 that this case be maintained as a class action. Defendants have opposed the Motion, arguing that a class action would serve no useful purpose in this case. Having considered the briefs of the parties, the record to date in this action, and the oral arguments of the parties, the court concludes that the prerequisites for maintaining a class action set out in Fed. R. Civ. P. 23(a) are met in this case, and that this action may be maintained as a class action under Fed. R. Civ. P. 23(b)(2). Therefore, plaintiff's Motion for determination of class action is hereby granted, and this action shall henceforth be maintained as a class action on behalf of the following classes:

(1) A Medicare beneficiaries' class consisting of all past, present and future Medicare beneficiaries enrolled in the Supplementary and Medical Insurance Benefits for the Aged and Disabled Program (42 U.S.C. §§-1395j-1395w), commonly known as Part B of Medicare Program, who have sought or desire to secure Medicare reimbursement for CT head scan services during such period that Medicare reimbursement for CT services may have been and/or may be subject to the alleged arbitrary ceilings more fully described in the Complaint in this action; and

(2) A physicians' class consisting of all physicians and physician-directed clinics which now (or in the future) own, operate and use CT scanners in rendering head scan services to Medicare patients enrolled under Part B of the Medicare Program during such period that Medicare reimbursement for CT services

may have been and/or may be subject to the alleged arbitrary ceilings more fully described in the Complaint in this action.

AND IT IS SO ORDERED.

/s/ Charles E. Simons, Jr..
CHARLES E. SIMONS, JR.
United States District Judge

Aiken, S.C.

October 19, 1981

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

Civil Action No. 79-2311-6

EULA B. STARNES, ET AL., PLAINTIFFS

vs.

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, ET AL., DEFENDANTS

ORDER

Plaintiffs, Medicare beneficiaries enrolled in Part B of the Medicare Program ("Part B") and physicians and physician-directed clinics which own, operate and use computerized tomography ("CT") scanners in rendering CT head scan services to Medicare patients, brought this suit as a class action to challenge the establishment and implementation by defendants of certain alleged regional and nationwide ceilings or "caps" on Part B reimbursment for CT head scans (hereinafter the "caps").* Defendants, the Secretary of Health and Human Services ("HHS") and certain private insurance carriers under contract with the Secretary, are responsible for supervising and conducting the administration of Part B.

Part B is a voluntary insurance program which provides medical insurance benefits for aged and disabled individuals who elect to enroll in the program.

* The Medicare program is governed by 42 U.S.C. § 1395 *et seq.* (Title XVIII of the Social Security Act, as amended) (hereinafter the "Medicare Act").

42 U.S.C. § 1395j. It is financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government. Subject to certain deductibles and coinsurance requirements, a Part B beneficiary is generally entitled to have payments made to him, or on his behalf to an assignee, for the reasonable charge for physicians' and other medical services covered by the program.

Plaintiffs challenge the caps on various procedural, substantive, and constitutional grounds. Plaintiffs contend that the caps were established in violation of the procedural rulemaking requirements of the Administrative Procedure Act ("APA") (5 U.S.C. §§ 552-53). Plaintiffs further contend that the caps are substantively invalid in that they are lower than the actual, customary, and prevailing charge criteria for reasonable charge determinations under Part B (42 U.S.C. § 1395u(b)(3)); they preclude Part B carriers from performing their duties under the governing statute and regulations (42 U.S.C. § 1395u(a)(1)(A); 42 C.F.R. §§ 405.501, 405.502(c)); and they violate fundamental tenents of Medicare law pertaining to the delivery of, and access to, health services (42 U.S.C. §§ 1395, 1395a). Finally, plaintiffs assert that the caps violate their constitutional guarantees of equal protection and due process.

On March 6, 1980, this Court entered an Order enjoining defendants from implementing the caps "until such time, if any, as the Secretary may lawfully promulgate regulations authorizing HEW [now HHS] to set specific reimbursement caps for CT head scan services" on the ground that the caps were not established and implemented in accordance with the procedural rulemaking requirements of the APA. The Court determined that its subject matter jurisdiction

was founded upon 28 U.S.C. § 1331 and the reasoning enunciated in *Hopewell Nursing Home, Inc.* v. *Califano*, CCH Medicare and Medicaid Guide, ¶ 28,718 (D. S.C., December 20, 1977), and that *Weinberger* v. *Salfi*, 422 U.S. 749 (1975) and 42 U.S.C. § 405(h), did not preclude judicial review where the claims presented were not otherwise reviewable. No decision was reached concerning plaintiffs' substantive and constitutional claims.

No regulations authorizing the caps have been promulgated by the Secretary, and the March 6, 1980 Order remains in effect. Plaintiffs' motion for summary judgment seeking a permanent injunction against future implementation of the caps and an order requiring reimbursement adjustments where the caps were inconsistent with the reasonable charge methodology previously in effect is pending.

On October 20, 1981, this Court determined that this action may be maintained as a class action under Fed.R.Civ.P. 23(b)(2) and certified two nationwide plaintiff classes: (1) all past, present, and future Medicare beneficiaries enrolled in Part B who have sought or desire to secure Medicare reimbursement for CT head scan services during such period that Medicare reimbursement for CT services may have been and/or may be subject to the caps; and (2) all physicians and physician-directed clinics which now (or in the future) own, operate, and use CT head scanners in rendering head scan services to part B Medicare beneficiaries during the same period. The Court also declined to dismiss the defendant carriers as parties.

This matter is now before the Court on defendants' Motion to Dismiss for Lack of Jurisdiction prompted by the recent decision of the Court of Appeals for the

Fourth Circuit, which reversed the jurisdictional holding of the District Court in *Hopewell, supra. Hopewell Nursing Home, Inc.* v. *Schweiker*, 666 F.2d 34 (4th Cir. 1981). It is the defendants' position that Congress expressly precluded judicial review of Part B reimbursement disputes such as this one by incorporating into the Medicare Act the provisions of 42 U.S.C. § 405(h). See 42 U.S.C. § 1395ii. Section 405(h) provides, in part, as follows:

> No finding of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under § 41 of Title 28 to recover on any claim arising under this subchapter.

The Medicare statute provides for judicial review of certain beneficiary claims (i.e., the determination of whether an individual is entitled to benefits under Part A or Part B of the Medicare program, and the determination of the amount of benefits under Part A.) 42 U.S.C. § 1395ff. Defendants argue that because there is no statutory provision for obtaining judicial review of Part B benefit determinations, § 405(h) precludes such review and deprives this court of subject matter jurisdiction over this action. The legislative history of these Medicare provisions is cited extensively by defendants to support their contention that Congress intended to preclude entirely judicial review of claims respecting the amount of benefits payable under Part B. Moreover, defendants contend that all of plaintiffs' claims arise under the Medicare statute and that judicial review of the entire action is barred. *Weinberger* v. *Salfi*, 422 U.S. 749 (1975).

This court rejected defendants' jurisdiction arguments when it issued its March 6, 1980 Order, and concluded that 42 U.S.C. § 405(h) does "not preclude judicial review where the claims presented are not otherwise reviewable." Since that conclusion was premised in part on reasoning articulated in the district court's opinion in *Hopewell Nursing Home, Inc.* v. *Califano, supra*, and since the Court of Appeals for the Fourth Circuit reversed the *Hopewell* court's decision, defendants argue again that the instant action should be dismissed.

Hopewell was brought as a class action by nursing homes that participated as providers in the Medicare program and their owner-administrators to challenge certain intermediary surveys used to compile ranges of compensation paid to administrators in the region, which were in turn used by the intermediaries in making reasonable cost determinations for reimbursement purposes.* The *Hopewell* plaintiffs challenged the surveys and the use of the ranges of compensation as being in violation of Medicare law and regulations; contrary to the Secretary's own instructions; arbitrary and capricious, unconstitutional, contrary to the rulemaking requirements of the APA, and in violation of the Federal Records Act.

The district court held in *Hopewell* that it had subject matter jurisdiction under 28 U.S.C. § 1331 (general federal question jurisdiction) and that the surveys were flawed and violated the Medicare law and regulations. It ordered defendants to recalculate reimbursement payable to plaintiffs in 1971 and each

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* Fiscal intermediaries are the Medicare Part A counterparts of Part B carriers. Providers such as hospitals and nursing homes, are generally reimbursed for their reasonable costs under Part A.

year thereafter. The Court of Appeals reversed, holding that by operation of § 405(h), subject matter jurisdiction under 28 U.S.C. § 1331 was precluded and that plaintiffs' failure to comply with the statutory jurisdictional prerequisites of 42 U.S.C. § 1395oo, which provides for appeal to the Provider Reimbursement Review Board (PRRB) and subsequent judicial review, deprived the district court of jurisdiction under the Medicare statute. The court also found that mandamus jurisdiction was unavailable.

The Court of Appeals remanded the *Hopewell* case to the district court with instructions to dismiss those of plaintiffs' claims that arose after 1973, when the statute's Part A jurisdictional provisions became operative. With respect to pre-1973 claims for which the Medicare statute provided no avenue to federal court review, the Court of Appeals deferred judgment, holding that only after plaintiffs had satisfied the statute's jurisdictional prerequisites for post-1973 should the district court examine its authority over the pre-1973 portion of the case. In so doing, the court followed the decision of the District of Columbia Circuit in *Humana of South Carolina, Inc.* v. *Califano*, 590 F.2d 1070 (D.C. Cir. 1978).

It is plaintiffs' position that subject matter jurisdiction lies under 28 U.S.C. § 1331. First, plaintiffs contend that procedural rulemaking challenges under the APA are subject to judicial review notwithstanding 42 U.S.C. § 405(h) and *Salfi* since they arise under the APA, rather than the Medicare Act. Principal reliance in this regard is placed upon the decision of the District of Columbia Circuit in the *Humana* case, *supra*, which distinguished procedural rulemaking challenges under the APA from substantive challenges to Medicare reimbursement determinations. 590 F.2d at 1080.

Next, plaintiffs argue that the reasoning of the Fourth Circuit in *Hopewell* supports subject matter jurisdiction over their substantive and constitutional challenges under 28 U.S.C. § 1331. In declining to dismiss the pre-PRRB Part A claims, the Fourth Circuit observed that the preclusion of all judicial review would be of "disputable constitutionality." *Hopewell Nursing Home, Inc.*, 666 F.2d at 41. By analogy to the Fourth Circuit's treatment of those pre-PRRB Part A claims, plaintiffs argue that it would be improper to dismiss their substantive and constitutional challenges since the Medicare Act does not establish administrative procedures culminating in judicial review under Part B.

Furthermore, plaintiffs attempt to distinguish the facts in *Hopewell* and this case with respect to the exhaustion issue. While the plaintiffs in *Hopewell* made no attempt to secure administrative review of their claims through the Part A PRRB process, certain Medicare beneficiaries and physicians, including several named plaintiffs in this case, challenged the CT caps by appealing reimbursement determinations to carrier-appointed hearing officers, without success. The only avenue of appeal of Part B reimbursement disputes is an appeal of claims involving more than $100 to a Part B carrier-appointed hearing officer. 42 U.S.C. § 1395u(b)(3)(C). Plaintiffs argue that this Part B appeal mechanism is analogous to the pre-PRRB Part A appeal mechanism, which provided for appeal only to Part A intermediary hearing officers.

Plaintiffs also point out that they sought relief from the Secretary at a regional and then a national level prior to bringing this action, and they argue that the Office of General Counsel advised the Administrator of the Health Care Financing Adminis-

tration that the caps were illegal under the APA in that they were not established through rulemaking and that Part B carriers had advised the Secretary that the caps were unreasonable and illegal. Accordingly, plaintiffs contend that there were no further administrative appeals to exhaust.

As an additional basis for jurisdiction, plaintiffs assert that mandamus jurisdiction lies against the Secretary under 28 U.S.C. § 1361. *Arkansas Soc'y of Pathologists* v. *Harris*, Medicare and Medicaid Guide (CCH) ¶ 30,706 (E.D. Ark., August 22, 1980); *Waitley* v. *Califano*, Medicare and Medicaid Guide (CCH) ¶ 39,141 (D. Kan. 1978); *see Burnett* v. *Tolson*, 474 F.2d 677 (4th Cir. 1973). In *Hopewell*, the Fourth Circuit denied mandamus jurisdiction, finding it particularly inappropriate in view of the absence of a showing by the plaintiffs that the Secretary would not act on claims presented to him. 666 F.2d at 42. Plaintiffs have attempted to distinguish *Hopewell*, citing their efforts to secure administrative relief from the CT caps, and assert that mandamus jurisdiction would lie under the facts of this case.

In its March 6, 1980 Order, this Court concluded that it had subject matter jurisdiction under 28 U.S.C. § 1331. Having examined *Hopewell*, this Court remains unconvinced that its earlier finding of jurisdiction was erroneous. The Court believes that plaintiffs' APA procedural rulemaking claim is not barred by 42 U.S.C. § 405(h). In view of the Fourth Circuit's treatment and the pre-PRRB claims in *Hopewell*, the Court does not believe that all judicial review of plaintiffs' substantive and constitutional challenges should be precluded. Therefore, defendants' Motion to Dismiss is DENIED.

The Court believes, however, that this order involves a controlling question of law as to which there is substantial ground for difference of opinion, *i.e.*, whether 42 U.S.C. § 405(h) precludes judicial review of plaintiffs' procedural and substantive claims.

The court is aware that two cases now pending before the Supreme Court may involve related questions, but that neither squarely presents the issue decided here. See *Erika, Inc.* v. *United States*, 647 F.2d 129 (Ct. Cl. 1981), *cert. granted*, No. 81-1594, —— U.S. ——, 101 S.Ct. 2312 (1981); *McClure* v. *Harris*, 503 F. Supp. 409 (N.D. Cal. 1981), *cert. granted*, No. 81-212, —— U.S. ——, 101 S.Ct. 2298 (1981). For these reasons, the Court is of the opinion that an immediate appeal from the order may materially advance the ultimate termination of the litigation, and therefore certifies this order for appeal in accordance with the provisions of 28 U.S.C. § 1292(b).

It is further ordered by this Court that action on plaintiffs' pending Motion for Summary Judgment and Defendants' Motion for Reconsideration of Class Determination be continued pending resolution of the jurisdictional question by the Fourth Circuit Court of Appeals.

/s/ Charles E. Simons, Jr.
CHARLES E. SIMONS, JR.
Chief Judge, United States
District Court

Columbia, S.C.
April 15, 1982

APPENDIX F

STATUTORY PROVISIONS INVOLVED

1. 28 U.S.C. (Supp. V) 1331 provides:

Federal question

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

2. 28 U.S.C. 1361 provides:

Action to compel an officer of the United States to perform his duty

The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

3. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), provides:

(h) Finality of Secretary's decision

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

4. Section 1869(a) and (b) of the Social Security Act, 42 U.S.C. 1395ff(a) and (b), provides:

Determinations of Secretary

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or subsection 1819, or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

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No. 83-1149

Supreme Court of the United States

October Term, 1983

MARGARET M. HECKLER, Secretary of Health and Human Services, et al.,

Petitioners,

vs.

EULA B. STARNES, et al.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Court of Appeals correctly decided to uphold the District Court's exercise of subject matter jurisdiction under 28 U.S.C. § 1331 to enjoin the Secretary's further implementation of arbitrary caps on Medicare Part B reimbursement for covered medical services that were established in violation of the procedural rulemaking requirements of the Administrative Procedure Act (5 U.S.C. § 533)?

2. Whether the District Court has jurisdiction under 28 U.S.C. § 1331 to review respondents' procedural constitutional and statutory challenges to the Secretary's unlawful conduct in the administration of the Medicare Part B program, as held by the Court of Appeals?

3. Whether the District Court has jurisdiction under 28 U.S.C. § 1361 to review respondents' rulemaking challenge and their constitutional and statutory challenges to the Secretary's administration of the Medicare Part B program, as held by the Court of Appeals?

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No. 83-1149

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BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

STATUTORY PROVISIONS INVOLVED

5 U.S.C. § 553 is reproduced at App., *infra*. Other relevant statutes are reproduced in App. F to the Secretary's petition.

STATEMENT OF CASE

The matter presently before the Court on petition for writ of certiorari is the product of administrative arrogance, attempted defiance of clear Congressional mandates, and scorn for judicial supervision. Acting with flagrant disregard of the procedural safeguards embodied in the rulemaking requirements of the Administrative Procedure Act ("APA"), 5 U.S.C. § 553, and constitutional and statutory mandates guaranteeing due process and fairness in the administration of the Medicare Part B program, the Secretary during 1977-78 imposed arbitrary caps on reimbursement under Medicare Part B for covered CT scanning services, effectively eliminating the provision of such services in physicians' offices and forcing Medicare beneficiaries to obtain CT scans, if at all, in hospitals where the services were costlier and resulting delays were sometimes life threatening.

As recently recognized by this Court, Congress intended for private insurance carriers to play a central role in administering Medicare Part B and in providing beneficiaries with fair hearings on benefit controversies through carrier-appointed hearing officers. *Schweiker v. McClure,* 456 U.S. 188 (1982). These statutory functions of Part B carriers were usurped with respect to CT scanning services through the abusive administrative actions of the Secretary taken over strong objections of carriers throughout the nation and contrary to the advice of the Secretary's own counsel that the imposition of the caps would be illegal if not subjected to rulemaking and shown during the rulemaking process to be reasonable.

For such administrative misconduct, the Secretary seeks absolute and unquestioned immunity from judicial review. In this pursuit, the Secretary mischaracterizes the nature of respondents' action as one challenging the appropriateness of the amount of benefits paid on claims for CT scans under Medicare Part B. This mischaracterization of the case is an essential element of the Secretary's argument that 42 U.S.C. §§ 405(h) and 1395ff are bars to the exercise of subject matter jurisdiction over respondents' challenges. The Secretary's position, simply stated, is that she should have free rein to act as arbitrarily as she desires, without concern for judicial intervention, with respect to matters having any direct or indirect bearing upon the Medicare Part B program.

Contrary to the Secretary's misleading statement of the case, respondents have not challenged the reasonableness of the amount of benefits paid for CT scans. Respondents seek the aid of the judicial system only to ensure that Part B is administered according to the procedures established by Congress and pursuant to lawfully promulgated regulations; they do not seek monetary relief. If the Medicare program is lawfully administered, then respondents will be satisfied with the amounts of benefits determined to be allowable through the statutory carrier review and hearing process, whatever those determinations may be.

Drawing upon a substantial body of case law, including recent decisions of this Court, the District Court and the Court of Appeals have on three occasions during the past five years rejected the Secretary's plea for an absolute bar to judicial review of respondents' challenges. In

her petition the Secretary attempts again to resurrect the issue of jurisdiction and to prolong further a final determination on the merits. The case law provides overwhelming support for judicial review under 28 U.S.C. §§ 1331 and 1361. Thus, the Secretary's petition should be denied.

1. *Medicare Part B.* The Medicare program, a health insurance program for the aged and disabled, consists of two basic components, Parts A (42 U.S.C. §§ 1395c *et seq.*) and B (42 U.S.C. §§ 1395j *et seq.*). Generally, Part A provides insurance for hospital and other specified institutional health care. Part B, which is involved in this action, provides insurance for covered medical services of physicians and other specified suppliers.

Respondents accept the Secretary's general description of Part B and its administration by Part B carriers (Pet. for Cert. 2-4), with the exception of the following clarification of certain misstatements and key omissions.

In making "reasonable charge" determinations, carriers are required by statute to apply two statutory limitations: (a) "customary" charges for similar services generally made by the physician who furnishes the services; and (b) the "prevailing" charges in the locality for similar services. 42 U.S.C. § 1395u (b) (3). Customary and prevailing charge screens are established by the carriers for this purpose. If a physician's actual charge for a service does not exceed the customary and prevail-

ing charge limitations, the actual charge is the "reasonable charge" and the basis for payment of benefits by the carrier.[1]

By regulation, the Secretary has acknowledged the statutory mandate that carriers, rather than government officials, are to "exercise judgment" on a case-by-case basis in making reasonable charge determinations. 42 C.F.R. §§ 405.502(c), 405.502(d). These determinations are to be made in accordance with broad "principles" issued by the Health Care Financing Administration ("HCFA"), the component of the Department of Health and Human Services ("HHS") responsible for the Medicare program. 42 C.F.R. § 405.502(d). The Secretary asserts that such principles are contained in "regulations and policy guidelines" issued through HCFA. Pet. for Cert. 3. The Secretary's regulation clearly states, however, that "[t]he *principles* in §§ 405.503-405.507 establish the criteria for making such determinations in accordance with the statutory provisions." 42 C.F.R. § 405.502(d) (emphasis added). Thus, the regulations limit the principles by which carriers are guided in exercising their discretion to those published in the regulations at §§ 405.503-405.507, and those sections of the regulations relate solely to the "customary" and "prevailing" charge criteria prescribed by statute for reasonable charge determinations. There is no authority in the statute or regulations for carriers to be guided by "policy guidelines" that are not lawfully promulgated in the regulations.

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[1]The statute also imposes an "economic index" limitation on annual increases in the prevailing charge limitation for physician services. 42 U.S.C. § 1395u (b) (3). The CT scan caps in question are not based on the economic index limitation. In fact, the caps rendered the economic index limitation meaningless with respect to CT scanning services.

As the Secretary acknowledges, the carrier review and hearing process prescribed by statute is restricted to beneficiary (or assignee) dissatisfaction with the carrier's initial determination as to the allowable amount of benefits. 42 U.S.C. § 1395u (b) (3) (C); 42 C.F.R. §§ 405.801(a), 405.807. The Secretary conspicuously fails to note, however, that the statute requires that beneficiaries be afforded a "fair" hearing when an amount of $100 or more is in controversy, and that the Secretary has bound carrier-appointed hearing officers to comply with "policy statements, instructions and other guides" issued by HCFA. 42 C.F.R. § 405.860.

Unlike many reimbursement disputes under Part A, disputes as to the proper amount of benefits allowable under Part B are not subject to judicial review under the statute. Beneficiaries must rely upon the carrier or a carrier-appointed hearing officer to make a fair and lawful determination on that subject.

2. *Background of the CT dispute.* Computerized tomography ("CT") scanning, also known as computerized axial tomography ("CAT"), is a highly effective diagnostic tool for a variety of cranial disorders (*e.g.*, tumors, atrophy, hemorrhage, skull fractures) the use of which enables the elimination of other time-consuming, painful, less effective, riskier, and more costly diagnostic procedures. The developers of CT scanning were recognized with the award of the 1979 Nobel Prize in Physiology or Medicine.

CT head scanning became a covered service under Medicare Part B in 1976.[2] At that time, carriers based reasonable charge determinations for CT head scans on the actual charges of physicians, subject to the customary and prevailing charge criteria that were then, and still are, prescribed in the statute and the Secretary's regulations.

In July 1977, the Region Office (Atlanta) of the Medicare Bureau (the predecessor to HCFA) first established caps on Part B reimbursement for CT head scans at $150 through letters issued to all carriers in Region IV. A $150 nationwide cap was then established by the Medicare Bureau in December 1977, by a memorandum issued to all Regional Medicare Directors. The Medicare Bureau slightly adjusted the nationwide caps in September 1978, through the issuance of Intermediary Letter 78-38 to all Part B carriers. The Intermediary Letter adjusted the caps to $157.50 or $172.50 depending upon the use of contrast enhancement. These caps have never been subjected to formal rulemaking.

Upon establishment of the caps, carriers throughout the United States questioned their legality, challenged them as being inequitable and unreasonable, and request-

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[2]The Secretary references the portion of the March 1978 National Guidelines for Health Planning pertaining to CT scanning. (Pet. for Cert. 5). The Secretary fails to note that those Guidelines applied only to hospital-based scanners, which are subject to Part A reimbursement, and ignores the fact that those Guidelines were subsequently withdrawn by the Secretary with the embarrassing admission that they did not take into account the state-of-the-art of CT scanning; they were rigid and inflexible; and they had obstructed the distribution of "needed" scanners, "thus inhibiting access to necessary CT scanning services and preventing the public from fully benefiting from their potential." 47 *Fed. Reg.* 53853 (1982).

ed approval of exceptions, but to no avail. (C.A. App. 79-81, 87-94, 96-102). The President of one of the carrier defendants in this action testified that "[a]s a result of these ceilings, the duties of this defendant are purely ministerial and this defendant is not permitted to exercise any discretion in connection with them." (C.A. App. 144).

Named respondents and members of the respondent classes throughout the United States challenged the caps through the carrier review and hearing process prescribed by statute and regulations. In each case, the carriers and hearing officers concluded that they had no discretion to ignore the caps. When they considered doing so, they received direct instructions from HCFA officials to apply the caps. (C.A. App. 122-128, 152-53, 164-91, 202-14).

In addition to pursuing individual appeals to carrier-appointed hearing officers, respondents, individually and through representative national organizations, sought administrative relief from the caps through extensive discussions with, and written submissions to, HCFA Region IV and then to the Secretary at the national level during the period 1977-79, but to no avail. (C.A. App. 204-05).

During the same period, in August 1978, the chief counsel for HCFA advised the HCFA Administrator that, in order to establish the caps lawfully, HCFA "will have to (1) proceed by rulemaking rather than by intermediary letter and (2) make a case in the rulemaking record for why the caps selected are reasonable." (C.A. App. 37). That legal opinion was ignored. A subsequent warning from the Director of the Medicare Bureau to the HCFA Administrator that "[w]e are already on notice that the Office of General Counsel considers the guidelines that

we recently issued on payment limits for CT scans legally unsupportable" also fell on deaf ears. (C.A. App. 110).

3. *Judicial proceedings below.* Having no avenue of relief available except resort to the courts, respondents brought this action in November 1979. Respondents asserted that the caps were established in violation of the procedural rulemaking requirements of the APA. (C.A. App. 17). Challenges to the Secretary's action were also brought on other grounds. Respondents raised constitutional due process and equal protection challenges, attacking the procedure by which the caps were enforced and implemented and their arbitrary and discriminatory nature. (C.A. App. 16-17). Respondents further contended that the procedure by which Part B determinations are made under the caps is contrary to the Medicare statute and regulations. (C.A. App. 9-10).

Respondents sought injunctive relief from further implementation of the caps and for an order directing that determinations as to Part B reimbursement for CT head scan services be made by Part B carriers without regard to the Secretary's caps. (C.A. App. 20-21). Respondents did not seek to recover on any claim for Part B benefits; no monetary relief was requested.

Finding that the Secretary's establishment of the caps violated the procedural rulemaking requirements of the APA, the District Court entered an Order on March 6, 1980, granting respondents' request for a preliminary injunction.[3] The District Court enjoined further implementation of the caps "until such time, if any, as the

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[3]The unpublished Orders of the District Court are attached as Appendices to the Secretary's petition.

Secretary may lawfully promulgate regulations authorizing HEW [the predecessor to HHS] to set specific reimbursement caps for CT head scan services." (C.A. App. 141-42). Jurisdiction was founded upon 28 U.S.C. § 1331 with respect to the APA rulemaking challenge.[4] No decision was reached on the merits in the March 6, 1980 Order with respect to the other challenges presented by respondents.

Notwithstanding the representations of her counsel to the District Court in December 1979, that appropriate regulations were being drafted for promulgation, the Secretary has never promulgated regulations authorizing the caps. Accordingly, the March 6, 1980 preliminary injunction remains in effect.

An interlocutory appeal, to which this matter relates, was brought by the Secretary to the United States Court of Appeals for the Fourth Circuit in response to a subsequent Order entered by the District Court on April 16, 1982, denying the Secretary's motion to dismiss for lack of subject matter jurisdiction. (C.A. App. 155-63). The District Court reaffirmed its finding of federal question jurisdiction over the APA rulemaking claim and added that judicial review would be appropriate for other challenges brought by respondents to the establishment of the caps. (C.A. App. 161-62). The District Court certified the issue of subject matter jurisdiction to the Court of Appeals.

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[4]Having found jurisdiction to exist under 28 U.S.C. § 1331, the District Court did not address the availability of mandamus jurisdiction under 28 U.S.C. § 1361.

On interlocutory appeal to the Fourth Circuit of the jurisdictional issue, the Secretary contended that 42 U.S.C. §§ 405(h) and 1395ff are absolute bars to judicial review of any conduct of the Secretary having any direct or indirect impact on the administration of Medicare Part B, even if the action arises under the procedural rulemaking provisions of the APA, on constitutional grounds, or is otherwise collateral to benefit determinations. Drawing upon a substantial body of case law, the Court of Appeals disagreed and affirmed the District Court's exercise of jurisdiction over the APA rulemaking claim under 28 U.S.C. § 1331. *Starnes v. Schweiker*, 715 F.2d 134, 140-41 (4th Cir. 1983). Further, the Fourth Circuit concluded that respondents' alleged violations by the Secretary of the Medicare statute and of their constitutional rights were subject to federal question jurisdiction since those claims were essentially to enforce lawful conduct on the part of the Secretary rather than to recover benefits. 715 F.2d at 141.[5]

The Fourth Circuit also concluded that mandamus jurisdiction would be available under 28 U.S.C. § 1361 to decide respondents' challenges if federal question jurisdiction were not available, pointing to "an impressive array of cases" upholding mandamus jurisdiction to review procedures employed in administering social security benefits. 715 F.2d at 141-42. The Court of Appeals observed

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[5]Although the Fourth Circuit determined that respondents' action was not one to recover benefits, it observed that an action to reopen past benefit determinations under Part B on constitutional grounds would be subject to judicial review, notwithstanding 42 U.S.C. § 1395ff and this Court's decision in *United States v. Erika, Inc.*, 456 U.S. 201 (1982), noting that no constitutional issue was pressed before this Court in *Erika*.

that the traditional conditions for the exercise of mandamus jurisdiction may be met in this case if federal question jurisdiction is not available, pointing out that respondents have exhausted all available administrative remedies as well as some informal extra-judicial ones. 715 F.2d at 142.

REASONS FOR DENYING THE WRIT

I. The Decision of the Court of Appeals Finding Jurisdiction Under 28 U.S.C. § 1331 Is Not Inconsistent With Prior Decisions of This Court.

In her petition the Secretary ignores the true nature of respondents' action and with calculated precision mischaracterizes the action as "a challenge to the amount determined to be the 'reasonable charge' under Part B of the Medicare Program" for CT scans. Pet. for Cert. 4. Working from this faulty premise, the Secretary argues that judicial review of respondents' challenges is foreclosed by 42 U.S.C. §§ 405(h) and 1395ff, relying upon this Court's decisions in *Weinberger v. Salfi*, 422 U.S. 749 (1975), and *United States v. Erika, Inc.*, 456 U.S. 201 (1982). The statutory provisions which form the springboard for the Secretary's argument are inapplicable to the present case.

This is not an action challenging "the amount of benefits payable for CT scans," contrary to the Secretary's self-serving mischaracterization. Pet. for Cert. 11. As described above, the appropriate amount of benefits is not an issue here at all. It would be an issue for carrier determination, outside the judicial process, only if respondents' action is successful. Instead, respond-

ents challenge the very conduct of the Secretary which has precluded carriers from performing their duty to make reasonable charge determinations of the amount of benefits for CT scans in accordance with the governing statute and regulations.

The District Court's exercise of jurisdiction over respondents' APA procedural rulemaking challenge is supported by an abundance of authority, notwithstanding 42 U.S.C. § 405(h). The courts have consistently held that APA procedural rulemaking challenges by Medicare claimants to actions taken by the Secretary without notice, opportunity to comment, and publication in the *Federal Register* are subject to judicial review under 28 U.S.C. § 1331.[6] *E.g., National Ass'n of Home Health Agencies v. Schweiker*, 690 F.2d 932 (D.C. Cir. 1982), *cert. denied*, 103 S.Ct. 1,193 (1983); *Daniel Freeman Memorial Hospital v. Schweiker*, 656 F.2d 473, 476 (9th Cir. 1981); *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1,070, 1,080-81 (D.C. Cir. 1978). Such actions seek to vindicate an interest in procedural irregularity, rather than to recover on a claim arising under the Medicare statute as barred by 42 U.S.C. § 405(h). Moreover, a rulemaking challenge is an action arising under 5 U.S.C. § 553, rather than under the Medicare statute.

Similarly, there is no basis for asserting that *Erika* interprets 42 U.S.C. § 1395ff to preclude an APA rulemaking challenge to actions of the Secretary. Unlike the

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[6]The notice and comment requirements "were designed to assure fairness and mature consideration of rules of general application." *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759, 764 (1969). The rulemaking proceeding is intended to provide "procedural" protection. *Heckler v. Campbell*, 103 S.Ct. 1,952, 1,959 (1983).

present case, *Erika* involved a direct challenge to the determination of a carrier-appointed hearing officer as to the amount of benefits awarded to a supplier of medical services. The plaintiff's action in *Erika* was filed in the Court of Claims, and jurisdiction was asserted under The Tucker Act, 28 U.S.C. § 1491. No APA procedural rulemaking challenge was brought.

Recognizing the limited scope of the plaintiff's substantive challenge to the carrier's benefit amount determination, this Court narrowly framed the issue in *Erika* as follows:

> The question is whether the Court of Claims has jurisdiction to review determinations by private insurance carriers of the amount of benefits payment under Part B of the Medicare statute. 456 U.S. at 201.

The Court's opinion focused upon the statutory language of 42 U.S.C. § 1395ff and legislative history indicating Congressional intent not to authorize judicial review of Part B controversies as to the allowable "amount" of benefits. That discussion and the decision in *Erika* are inapplicable to respondents' APA rulemaking challenge. Neither 42 U.S.C. § 1395ff nor its legislative history even hint that Congress intended to bar judicial review of APA rulemaking claims because they might have an effect on the administration of Part B.

Similarly, there is nothing in the text or legislative history of 42 U.S.C. §§ 405(h) and 1395ff to suggest that judicial review under 28 U.S.C. § 1331 of the other procedural challenges brought by respondents to the Secretary's abusive administration of Part B with respect to CT scanning services is foreclosed. The Secretary's argument to that effect conflicts with this Court's decision in *Schweiker v. McClure*, 456 U.S. 188 (1982).

In *McClure*, a case decided on the same day as *Erika*, this Court implicitly recognized that procedural claims brought by Medicare Part B claimants are reviewable. The Court considered the merits of an action challenging the constitutionality of the Part B review and hearing process in *McClure*. Although the plaintiffs failed to succeed on the merits, this Court's consideration of the merits of their claim and its failure to question subject matter jurisdiction to consider the merits implicitly affirmed the lower court's determination that the plaintiffs' constitutional claims were collateral to their substantive claims for Medicare benefits and were therefore reviewable under the authority of *Mathews v. Eldridge*, 424 U.S. 319 (1976). *See McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980).

The exercise of jurisdiction over procedural challenges to the Secretary's conduct in the administration of the Medicare program notwithstanding a statutory bar to judicial review of substantive benefit determinations is also supported by a substantial body of circuit court decisions. *E.g., Hollingsworth v. Harris*, 608 F.2d 1,026, 1,027 (5th Cir. 1979); *Chelsea Community Hospital, SNF v. Michigan Blue Cross Ass'n*, 630 F.2d 1,131, 1,135 (6th Cir. 1980); *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283, 291-92 (8th Cir.), *cert. denied, sub nom., Faith Hospital Ass'n v. Blue Cross Hospital Services, Inc.*, 429 U.S. 977 (1976).

Finally, it is important to recognize that, unlike Medicare Part A and Title II disputes under the Social Security Act, there is no prescribed statutory procedure culminating in judicial review of Medicare Part B claims. Statutory foreclosure of judicial review of all challenges

to the Secretary's administration of Part B would be extraordinary and would be of disputable constitutionality. *Weinberger v. Salfi*, 422 U.S. 749, 762 (1975); *Johnson v. Robinson*, 415 U.S. 361, 366-67 (1974).

Salfi and its progeny of Title II cases, which have been relied upon by the Secretary as support for her assertion that 42 U.S.C. § 405(h) is an absolute bar of all judicial review, clearly indicate otherwise. In *Salfi* and *Mathews v. Eldridge*, 424 U.S. 319 (1976), the merits of the claims presented in those cases *were* addressed by this Court, and, as noted above, courts have subsequently interpreted *Eldridge* to authorize judicial review of procedural claims. Indeed, in *Califano v. Sanders*, 430 U.S. 99, 109 (1977), the Court pointed out that judicial review was available to the plaintiffs in *Salfi* and *Eldridge* under the statutory scheme in question and that an absolute bar to judicial review would presumably be unconstitutional, notwithstanding 42 U.S.C. § 405(h).

Thus, the decision of the Fourth Circuit finding jurisdiction under 28 U.S.C. § 1331 is entirely consistent with prior decisions of this Court.

II. The Decision of the Court of Appeals Finding Jurisdiction Under 28 U.S.C. § 1361 is Supported By Ample Case Law.

If jurisdiction were not available under 28 U.S.C. § 1331, mandamus jurisdiction would be available under the particular facts of this case under 28 U.S.C. § 1361. The federal mandamus statute, added by the Mandamus and Venue Act of 1962, 76 Stat. 744, provides an independent grant of jurisdiction to halt illegal action by federal officials:

> The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff. 28 U.S.C. § 1361.

The writ of mandamus may issue when there is (a) a clear right in the plaintiff to the relief sought; (b) a clear duty on the part of the defendant to do the act in question; and (c) no other adequate remedy available. *E.g., Burnett v. Tolson*, 474 F.2d 877 (4th Cir. 1973).

Respondents have demonstrated through their challenges to the establishment of the caps under APA rulemaking provisions and the Medicare statute and on constitutional grounds that the first two conditions of the mandamus test are met. Respondents' position is bolstered by the observations of carriers throughout the country that the caps are illegal, unreasonable, and inequitable and the Opinion of the Secretary's Office of General Counsel that the caps were not adopted in accordance with APA procedural rulemaking requirements. Indeed, the District Court has already upheld respondents' APA procedural rulemaking challenge on the merits. Further, as reasoned by the Fourth Circuit, the third condition is met if federal question jurisdiction is not available, especially since respondents have exhausted all available administrative remedies.

There is ample authority that mandamus jurisdiction will lie to review actions of the Secretary, notwithstanding 42 U.S.C. § 405(h). For an extensive analysis of the pertinent legislative history and prior case law see Judge Friendly's opinion in *Ellis v. Blum*, 643 F.2d 68 (2d Cir. 1981). *Accord, Kuehner v. Schweiker*, 717 F.2d 813 (3d Cir. 1983).

III. The Court Should Not Grant The Writ and Hold It On The Basis Of The Court's Consideration Of Issues Raised In Heckler v. Ringer, No. 82-1772 (Oct. Term, 1983).

In support of her petition, the Secretary further argues that this Court should grant the writ and hold the petition while it considers issues raised in a case presently before the Court styled *Heckler v. Ringer*, No. 82-1772 (Oct. Term, 1983). Arguing that the identical issue of jurisdiction under 28 U.S.C. §§ 1331 and 1361 is raised in *Ringer*, the Secretary implies that the Court's decision in *Ringer* would control the Court's determination in this case. A comparison of the facts and issues raised in *Ringer* with those in the instant case reveals the fallacy of the Secretary's position.

In contrast to the present case, *Ringer* involves a challenge by claimants to the Secretary's denial of reimbursement under Part A of the Medicare program. As explained by the Secretary in her brief in *Ringer*, Part A provides a significantly different scheme from that found in Part B for both administrative and judicial review. (Petitioner's Brief 3-5). Under 42 U.S.C. § 405(g), as incorporated by 42 U.S.C. § 1395ff(b) (1), a beneficiary is entitled to judicial review when there has been a final decision by the Secretary after a hearing on the claim for benefits. Administrative hearings of the type at issue in *Ringer* are conducted by Administrative Law Judges and are appealable to an Appeals Council prior to judicial review. Carriers and carrier-appointed hearing officers are not part of that process.

The Secretary's and the claimants' briefs in *Ringer* are largely devoted to the central issue of whether the

claimants satisfied the administrative prerequisite to judicial review imposed by 42 U.S.C. § 405(g) by either exhausting their administrative remedies or obtaining a waiver of the exhaustion requirement from the Secretary. The issue of exhaustion of administrative remedies as required by § 405(g) is unique to *Ringer* and the claimants' challenge under Part A. Exhaustion of administrative remedies is not an issue here.

Furthermore, unlike this case, the plaintiffs in *Ringer* did not press their APA rulemaking claim, and it was not considered by the courts below. The principal claim urged by respondents in the instant case is an APA procedural rulemaking claim which, as demonstrated above, is clearly not foreclosed by the provisions of the Social Security Act upon which the Secretary relies.

Accordingly, a decision in *Ringer* will not control the jurisdictional issues in the present case. The Secretary's plea based on *Ringer* appears even more suspect in light of the fact that the Secretary requests that the writ be granted but then held in abeyance. If the Secretary's petition were truly motivated in the present case by a concern over common issues of law, the Secretary's request would undoubtedly seek consolidation of the cases for simultaneous review. The Secretary's request is but another tactic to delay the ultimate determination on the merits in the present case and further aggravate respondents' expenses and injuries. Clearly, no profit could arise from the grant of a writ which would be held until the Court has made a decision on a factually and legally dissimilar case.

CONCLUSION

The Secretary's petition for a writ of certiorari should be denied. If granted, the petition should not be held in abeyance pending a final decision in *Ringer*.

Respectfully submitted,

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APPENDIX A

STATUTORY PROVISIONS INVOLVED[1]

5 U.S.C. § 553 provides:

(a) This section applies, according to the provisions thereof, except to the extent that there is involved —

(1) a military or foreign affairs function of the United States; or

(2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include —

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply —

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

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[1]Other pertinent statutory provisions are presented in Appendix F to the Secretary's Petition.

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except —

(1) a substantive rule which grants or recognizes an exemption or relieves a restriction;

(2) interpretative rules and statements of policy; or

(3) as otherwise provided by the agency for good cause found and published with the rule.

(e) Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.